State of Washington
Department of Labor and Industries

Payment Policies

for Services Provided to Injured Workers and Victims of Crime

Effective July 1, 2004

This document is also on the department's Internet site www.LNI.wa.gov.

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Highlights of Changes

This *Medical Aid Rules and Fee Schedules (*fee schedule) is effective for services provided on or after July 1, 2004. These highlights are intended for general reference; they are not a comprehensive list of all the changes in the fee schedule. Refer to the 2004 CPT© and HCPCS coding books for complete code descriptions and lists of new, deleted or revised codes.

WASHINGTON ADMINISTRATIVE CODE (WAC) AND PAYMENT CHANGES

- Cost of living adjustments were applied to RBRVS and anesthesia services and to most local codes.
- WAC 296-20-135 increased the RBRVS conversion factor from $50.58 to $50.63 and increased the anesthesia conversion factor from $2.80 per minute ($42.00 per 15 minutes) to $2.81 per minute ($42.15 per 15 minutes).
- WAC 296-23-220 and WAC 296-23-230 increased the maximum daily cap for physical and occupational therapy services to $104.12.

POLICY ADDITIONS, CHANGES AND CLARIFICATIONS

Professional Services

- Updated the after hours services section.
- Added Early Intervention Vocational Services Extension codes.
- Added Stand Alone Job Analysis codes.
- Expanded Vocational Services fee cap section to reflect graduated return to work and work hardening requirements.
- Expanded information and added explanations in “Physical Medicine CPT® Codes Billing Guidance on timed codes.
- Updated information and fees on obesity treatments.
- Created a Chiropractic Services section.
- Updated and clarified the information on billing multiple procedures.
- Replaced “Starred Surgical Procedures” section with “Minor Surgical Procedures.”
- Updated fee examples.

Facility Services

- Hospital Out-of-State percent of allowed charge factor updated.
- Updated Ambulatory Surgery Center modifiers affecting payment.
- Updated Brain Injury Rehabilitation rates.
- Updated and clarified the Nursing Home, Residential and Hospice Care Services section.
- Updated the Ambulatory Surgery Center fee examples.

Appendices

- Updated and revised Appendix G, Outpatient Formulary to reflect the new therapeutic interchange program (TIP).

Fee Schedules

- Fees have been updated.

Introduction

All providers must follow the administrative rules, medical coverage decisions and payment policies contained within the *Medical Aid Rules and Fee Schedules*, Provider Bulletins, and Provider Updates. If there are any services, procedures, or text contained in the physicians' Current Procedural Terminology (CPT®) and federal Healthcare Common Procedure Coding System (HCPCS) coding books that are in conflict with the *Medical Aid Rules and Fee Schedules*, the department's rules and policies take precedence (WAC 296-20-010). All policies in this document apply to claimants receiving benefits from the State Fund, the Crime Victims Compensation Program and Self-Insurers unless otherwise noted.

Questions may be directed to the Provider Hotline at 1-800-848-0811 or to the Crime Victims Compensation Program at 1-800-762-3716.

INTRODUCTION TABLE OF CONTENTS

GENERAL INFORMATION

EFFECTIVE DATE

This edition of the *Medical Aid Rules and Fee Schedules* is effective for services performed on or after July 1, 2004.

UPDATES AND CORRECTIONS TO THE FEE SCHEDULES

If necessary, corrections to the *Medical Aid Rules and Fee Schedules* will be published on the department's web site at http://www.LNI.wa.gov/ClaimsInsurance/ProviderPay/FeeSchedules/

Additional fee schedule and policy information is published throughout the year in the department's Provider Bulletins and Provider Updates that are available on the department's web site at http://www.LNI.wa.gov/ClaimsInsurance/Providers/ProviderBulletins/default.asp.

STATE AGENCIES' FEE SCHEDULE AND PAYMENT POLICY DEVELOPMENT

The Washington State government payers coordinate fee schedule and payment policy development. The intent of this coordination is to develop payment systems and policies that make billing and payment requirements as consistent as possible for providers.

The state government payers are:

- The Washington State Fund workers' compensation program (The State Fund), administered by the Department of Labor and Industries (L&I)
- The Uniform Medical Plan, administered by the Health Care Authority (HCA) for state employees and retirees
- The State Medicaid Program, administered by the Medical Assistance Administration (MAA) within the Department of Social and Health Services (DSHS)

These agencies comprise the Interagency Reimbursement Steering Committee (RSC). The RSC receives input from the State Agency Technical Advisory Group (TAG) on the development of fee schedules and payment policies. The TAG consists of representatives from almost all major state professional provider associations.

While the basis for most of the agencies' fee schedules is the same, payment and benefit levels differ because each agency has its own source of funding, benefit contracts, rates and conversion factors.

BECOMING A PROVIDER

WORKERS' COMPENSATION PROGRAM

A provider must have an active L&I provider account number to receive payment for treating a Washington injured worker.

Providers can apply for account numbers by completing a Provider Account Application (form F248-011-000) and Form W9 (form F248-036-000). These forms are available at http://www.LNI.wa.gov/ClaimsInsurance/ProviderPay/Billing/Provider/ or can be requested by contacting the department's Provider Accounts section or the Provider Hotline.

Contact Information

Provider Accounts
Department of Labor & Industries
PO Box 44261
Olympia, WA 98504-4261
360-902-5140

Provider Hotline
1-800-848-0811

More information about the provider application process is published in WAC 296-20-12401, which can be found in the Medical Aid Rules section.

CRIME VICTIMS COMPENSATION PROGRAM

Providers treating victims of crime must apply for separate accounts with the Crime Victims Compensation Program. Provider Applications (form F800-053-000) and Form W9 (form F800-065-000) for the Crime Victims Compensation Program are available on the department's web site at http://www.LNI.wa.gov/ClaimsInsurance/CrimeVictims/Forms/default.asp or can be requested by contacting the Crime Victims Compensation Program.

Contact Information

Crime Victims Compensation Program
Provider Registration
Crime Victims Compensation Program
Department of Labor and Industries
PO Box 44520
Olympia, WA 98504-4520
1-800-762-3716

BILLING INSTRUCTIONS AND FORMS

BILLING PROCEDURES

Billing procedures are outlined in WAC 296-20-125, which can be found in the Medical Aid Rules section.

BILLING MANUALS AND BILLING INSTRUCTIONS

The *General Provider Billing Manual* (publication F248-100-000) and the department's provider specific billing instructions contain billing guidelines, reporting and documentation requirements, resource lists and contact information. These publications can be requested from the department's Provider Accounts section or the Provider Hotline. (Refer to Becoming a Provider for contact information.)

BILLING FORMS

Providers must use the department's most recent billing forms. Using out-of-date billing forms may result in delayed payment. To order new billing forms or other department publications, complete the Medical Forms Request (located under Contact Information on the MARFS CD or on the department's web site at http://www.LNI.wa.gov/forms/pdf/208063a0.pdf) and send it to the department's warehouse (address listed on the form).

GENERAL BILLING TIPS

This symbol is placed next to billing tips throughout the policy sections to facilitate correct payments.

SUBMITTING CLAIM DOCUMENTS TO THE STATE FUND

Mailing State Fund bills, reports and correspondence to the correct addresses helps the department pay you promptly.

Billing Tip

Reports and chart notes must be mailed separately from bills. Sending reports or chart notes with your bill may delay or even prevent the information from reaching the claims manager.

Item	State Fund Mailing Address
Report of Industrial Injury or Occupational Disease – Accident Report F242-130-000	Department of Labor & Industries PO Box 44299 Olympia, WA 98504-4299
Correspondence, reports and chart notes for State Fund Claims and claim related documents other than bills.	Department of Labor & Industries PO Box 44291 Olympia, WA 98504-4291
State Fund Provider Account information updates	Department of Labor & Industries PO Box 44261 Olympia, WA 98504-4261
UB-92 Forms	Department of Labor & Industries PO Box 44266 Olympia, WA 98504-4266
Bills for Adjustments Bills for Retraining & Job Modification Bills for Home Nursing Bills using the Miscellaneous form	Department of Labor & Industries PO Box 44267 Olympia, WA 98504-4267
Bills for Pharmacy and Compound Prescriptions	Department of Labor & Industries PO Box 44268 Olympia, WA 98504-4268
HCFA 1500 Forms	Department of Labor & Industries PO Box 44269 Olympia, WA 98504-4269
State Fund Refunds (attach copy of remittance advice)	Cashier's Office Department of Labor & Industries PO Box 44835 Olympia, WA 98504-4835

TIPS FOR SUBMITTING DOCUMENTS TO THE STATE FUND

The State Fund uses an imaging system to store electronic copies of all documents submitted on injured workers' claims. This system cannot read some types of paper and has difficulty passing other types through automated machinery.

Do's

Following these tips can help the department process your documents promptly and accurately.

- Submit documents on white 8 ½ x 11- inch paper (one-side only).
- Leave ½ inch at the top of the page blank.
- Submit legible information.
- Put the patient's name and claim number in the upper right hand corner of each page.
- If there is no claim number available, substitute the patient's social security number.
- Emphasize text with asterisks or underlines.
- Staple together all documents pertaining to one claim.
- Include a key to any abbreviations used.
- Reference only one worker/patient in a narrative report or letter.

Don'ts

Please do not submit information in the following manner.

- Don't use colored paper, particularly hot or intense colors.
- Don't use thick or textured paper.
- Don't send carbonless paper.
- Don't use any highlighter markings.
- Don't place information within shaded areas.
- Don't use paper with black or dark borders, especially on the top border.
- Don't staple documents for different workers/patients together.

Following the above tips can prevent significant delays in claim management and bill payment and can help you avoid department requests for information you have already submitted.

DOCUMENTATION REQUIREMENTS

Providers must maintain documentation in workers' medical files to verify the level, type and extent of services provided to injured workers. The department may deny or reduce a provider's level of payment for a specific visit or service if the required documentation is not provided or the level or type of service does not match the procedure code billed. No additional amount is payable for documentation required to support billing.

In addition to the documentation requirements published by the American Medical Association (AMA) in the CPT® book, the department or Self-Insurer has additional reporting and documentation requirements. These requirements are described in the provider specific sections and in WAC 296-20-06101. The department may pay separately for specialized reports or forms required for claims management. For specific documentation requirements see **Appendix H**.

RECORD KEEPING REQUIREMENTS

As a provider with a signed agreement with the department, you are the legal custodian of the injured workers' medical records. You must include subjective and objective findings, records of clinical assessment (diagnoses), as well as reports and interpretations of x-rays, laboratory studies and other key clinical information in patient charts.

Providers are required to keep all records necessary for the department to audit the provision of services for a minimum of five years (See WAC 296-20-02005).

Providers are required to keep all x-rays for a minimum of ten years (See WACs 296-20-121 and 296-23-140).

CHARTING FORMAT

For progress and ongoing care, use the standard **SOAP** (Subjective, Objective, Assessment, Plan and progress) format. In worker's compensation there is a unique need for work status information. To meet this need it is suggested adding **ER** to the SOAP contents. Chart notes must document employment issues, including a record of the patient's physical and medical ability to work, and information regarding any rehabilitation that the worker may need to undergo. Restrictions to recovery, any temporary or permanent physical limitations, and any unrelated condition(s) that may impede recovery must be documented.

SOAP-ER

S Subjective complaints
O Objective findings
A Assessment
P Plan and progress
E Employment issues
R Restrictions to recovery

OVERVIEW OF PAYMENT METHODS

HOSPITAL INPATIENT PAYMENT METHODS

The following is an overview of the department's payment methods for services in the hospital inpatient setting. Refer to Chapter 296-23A WAC in the Medical Aid Rules and the Facility Services section for more information.

All Patient Diagnosis Related Groups (AP-DRG)

The department uses All Patient Diagnosis Related Groups (AP-DRGs) to pay for most inpatient hospital services.

Percent of Allowed Charges (POAC)

The department uses a percent of allowed charges (POAC) payment method for some hospitals that are exempt from the AP-DRG payment method.

Self-Insurers and Crime Victims pay all hospitals using POAC.

The department uses the POAC as part of the outlier payment calculation for hospitals paid by the AP-DRG.

Per Diem

The department uses statewide average per diem rates for five AP-DRG categories: chemical dependency, psychiatric, rehabilitation, medical, and surgical. Some hospitals are paid for all inpatient services using per diem rates. Hospitals paid using the AP-DRG method are paid per diem rates for AP-DRGs designated as low volume.

HOSPITAL OUTPATIENT PAYMENT METHODS

The following is an overview of the department's payment methods for services in the hospital outpatient setting. Refer to Chapter 296-23A WAC in the Medical Aid Rules and the Facility Services section for more detailed information.

Ambulatory Payment Classifications (APC)

The department pays for most hospital outpatient services with the Ambulatory Payment Classifications (APC) payment method.

Professional Services Fee Schedule

The department pays for most services not paid with the APC payment method according to the maximum fees in the Professional Services Fee Schedule.

Self-Insurers and Crime Victims pay for most radiology, pathology, laboratory, physical therapy, and occupational therapy services according to the maximum fees in the Professional Services Fee Schedule.

Percent of Allowed Charges (POAC)

Hospital outpatient services that are not paid with the APC payment method, the Professional Services Fee Schedule or by department contract are paid by a POAC payment method.

Self-Insurers and Crime Victims use POAC to pay for hospital outpatient services that are not paid with the Professional Services Fee Schedule.

AMBULATORY SURGERY CENTER PAYMENT METHODS

Ambulatory Surgery Center (ASC) Groups

The department uses a modified version of the ASC Grouping system that was developed by the Centers for Medicare and Medicaid Services (CMS) to pay for facility services in an ASC. Refer to Chapter 296-23B WAC in the Medical Aid Rules and the Facility Services section for more information.

PROFESSIONAL PROVIDER PAYMENT METHODS

Resource Based Relative Value Scale (RBRVS)

The department uses the Resource Based Relative Value Scale (RBRVS) to pay for most professional services. More information about RBRVS is contained in the Professional Services section. Services priced according to the RBRVS fee schedule have a fee schedule indicator of R in the Professional Services Fee Schedule.

Anesthesia Fee Schedule

The department pays for most anesthesia services using anesthesia base and time units. More information is available in the Professional Services section.

Pharmacy Fee Schedule

The department pays pharmacies for drugs and medications according to the pharmacy fee schedule. More information is available in the Professional Services section.

Average Wholesale Price (AWP)

The department's rates for most drugs dispensed from a prescriber's office are priced based on a percentage of the average wholesale price (AWP) or the average average wholesale price (AAWP) of the drug. Drugs priced with an AWP or AAWP method have a fee schedule indicator of D and AWP in the Dollar Value columns in the Professional Services Fee Schedule.

Clinical Laboratory Fee Schedule

The department's clinical laboratory rates are based on a percentage of the clinical laboratory rates established by CMS. Services priced according to the department's clinical laboratory fee schedule have a fee schedule indicator of L in the Professional Services Fee Schedule.

Flat Fees

The department establishes rates for some services that are not priced with other payment methods. Services priced with flat fees have a fee schedule indicator of F in the Professional Services Fee Schedule.

Department Contracts

The department pays for some services by contract. Some of the services paid by contract include TENS units and supplies, utilization management, chronic pain management and chemically related illness center services. Services paid by department agreement have a fee schedule indicator of C in the Professional Services Fee Schedule. Crime Victims does not contract for these services. Please refer to the appropriate Provider Bulletin for additional information.

By Report

The department pays for some covered services on a by report basis as defined in WAC 296-20-01002. Services paid by report have a fee schedule indicator of N in the Professional Services Fee Schedule.

BILLING CODES AND MODIFIERS

The department's fee schedules use the federal HCPCS and agency unique local codes.

HCPCS Level I codes are the CPT® codes that are developed, updated and copyrighted annually by the AMA. There are three categories of CPT® codes:

> **CPT® Category I** codes are codes used for professional services and pathology and laboratory tests. These services are clinically recognized and generally accepted services, not newly emerging technologies. These codes consist of five numbers (e.g., 99201).
>
> **CPT® Category II** codes are optional codes used to facilitate data collection for tracking performance measurement. These codes consist of four numbers followed by the letter F (e.g., 0001F).
>
> **CPT® Category III** codes are temporary codes used to identify new and emerging technologies. These codes consist of four numbers followed by the letter T (e.g., 0001T).

HCPCS Level I modifiers are the CPT® modifiers that are developed, updated and copyrighted annually by the AMA. CPT® modifiers are used to indicate that a procedure or service has been altered without changing its definition. These modifiers consist of two numbers (e.g., -22). The department does not accept the five digit modifiers.

HCPCS Level II codes, commonly called HCPCS (pronounced Hick-Picks), are updated annually by CMS. CMS develops most of the codes. Codes beginning with D are developed and copyrighted by the American Dental Association (ADA) and are published in the *Current Dental Terminology* (CDT-3). HCPCS codes are used to identify miscellaneous services, supplies, materials, drugs and professional services not contained in the CPT® coding system. These codes begin with a single letter, followed by four numbers (e.g., K0007).

HCPCS Level II modifiers are developed and updated annually by CMS and are used to indicate that a procedure has been altered. These modifiers consist of two letters (e.g., -AA) or one letter and one number (e.g., -E1).

Local codes are used to identify department unique services or supplies. They consist of four numbers followed by one letter (except F and T). For example, 1040M must be used to code completion of the department's accident report form. The Health Insurance Portability and Accountability Act (HIPAA) may alter the use of some local codes.

Local modifiers are used to identify department unique alterations to services. They consist of one number and one letter (e.g., -1S). HIPAA may alter the use of some local modifiers.

The fee schedules do not contain the full text descriptions of the CPT®, HCPCS or CDT codes. Providers must bill according to the full text descriptions published in the CPT® and HCPCS books, which can be purchased from private sources. Refer to WAC 296-20-010(1) for additional information.

REFERENCE GUIDE FOR CODES AND MODIFIERS

	HCPCS Level I			HCPCS Level II	
	CPT® Category I	**CPT® Category II**	**CPT® Category III**	**HCPCS**	**L&I Local Codes**
Source	AMA/ CMS	AMA/ CMS	AMA/ CMS	CMS/ ADA	L&I
Code Format	5 numbers	4 numbers followed by F	4 numbers followed by T	1 letter and 4 numbers	4 numbers and 1 letter (not F or T)
Modifier Format	2 numbers	N/A	N/A	2 letters or 1 letter and 1 number	1 number and 1 letter
Purpose	Professional services, pathology and laboratory tests	Tracking codes to facilitate data collection for tracking performance measurement	Temporary codes for new and emerging technologies	Miscellaneous services, supplies, materials, drugs and professional services	L&I unique services, materials and supplies

PROVIDER BULLETINS AND UPDATES

Provider Bulletins and Provider Updates are adjuncts to the *Medical Aid Rules and Fee Schedules*, providing additional fee schedule, medical coverage decisions and policy information throughout the year.

Provider Bulletins give official notification of new or revised policies, programs and/or procedures that have not been previously published.

Provider Updates give official notification of corrections or important information, but the contents do not represent new policies, programs and/or procedures.

All users of the *Medical Aid Rules and Fee Schedules* are encouraged to keep Provider Bulletins and Updates on file. The bulletins and updates listed below were in effect at the time this fee schedule was printed.

Provider Bulletins are available on the department's web site at http://www.LNI.wa.gov/ClaimsInsurance/Providers/ProviderBulletins/default.asp. If you need hard copies, you may request them from the Provider Hotline at 1-800-848-0811.

If a bulletin or update is not listed here, it is either no longer current or has been incorporated into the *Medical Aid Rules and Fee Schedules*. Refer to the body of the *Medical Aid Rules and Fee Schedules* for changes affecting your practice.

CURRENT PROVIDER BULLETIN LIST

Bulletin Number	Date Issued	Subject	Contact Person	Phone Number
04-05	04/04	Preferred Drug List	Jaymie Mai	360-902-6792
04-03	01/04	Vocational Rehabilitation Rule Changes	Mary Kaempfe	360-902-6811
04-02	01/04	Implementation of Senate Bill 6088 and the Preferred Drug List	Jaymie Mai	360-902-6792
04-01	01/04	Coverage Decisions July 2003 to December 2003: Bone Morphogenic Protein, Intradiscal Electrothermal Therapy (IDET), Bone Cement for Kyphoplasty and Vertebroplasty, Thermal Shrinkage for the Treatment of Shoulder and Anterior Cruciate Ligament Instabililty	Grace Wang	360-902-5227
03-16	12/03	Review Criteria for Knee Surgery	LaVonda McCandless	360-902-6163
03-15	12/03	The Pharmacy On-Line Point-of-Services Billing System	Tom Davis	360-902-6687
03-13	11/03	Bone Growth Stimulators and Tobacco Use Cessation for Spinal Fusions	Jami Lifka	360-902-4941
03-12	10/03	Vocational Provider Performance Measurement Systems Enhancements	Mary Kaempfe	360-902-6811
03-11	09/03	Guideline on Facet Neurotomy	LaVonda McCandless	360-902-6163
03-10	08/03	Authorization for Interpretive Services/ Department Review of Providers	Paulette Golden	360-902-6823

Bulletin Number	Date Issued	Subject	Contact Person	Phone Number
03-09	07/03	Coverage Decisions, January – June 2003: ERMI Flexionater & Extensionater Devices, Extracorporeal Shockwave Therapy (ESWT), Vacuum Assisted Socket System (VASS)	Grace Wang	360-902-5227
03-08	06/03	Vocational Rehabilitation Rule Changes/ Referrals for Stand Alone & Provisional Job Analysis	Mary Kaempfe	360-902-6811
03-07	06/03	Implementation of the Prospective Drug Utilization Review Program	Jaymie Mai	360-902-6792
03-06	06/03	Chiropractic Consultant Program	Joanne McDaniel	360-902-6817
03-03	03/03	Guidelines for the Evaluation & Treatment of Injured Workers with Psychiatric Conditions	LaVonda McCandless	360-902-6163
03-02	02/03	Coverage Decisions: Autologous chondrocyte implant, Meniscal allograft transplant, Computerized prosthetic knee, UniSpacer	Grace Wang	360-902-5227
03-01	01/03	Interpreter Services	Paulette Golden	360-902-6823
02-12	12/02	Rating Permanent Impairment	Jami Lifka	360-902-4941
02-11	12/02	Guideline for the Use of Neurontin® in the Management of Neuropathic Pain	LaVonda McCandless	360-902-6163
02-07	10/02	General Vocational Rehabilitation and Claims Information	Mary Kaempfe	360-902-6811
02-06	7/02	Spinal Injection Policy	Lee Glass	360-902-4256
02-05	5/02	Hospital Outpatient Prospective Payment System Device Payment Pass-Through Payment Update	Jim King	360-902-4244
02-04	4/02	Utilization Review Program New UR Firm	Nikki D'Urso	360-902-5034
02-03	4/02	HIPAA Impacts on Labor & Industries	Jim King	360-902-4244
02-01	3/02	Guidelines for Shoulder Surgeries	LaVonda McCandless	360-902-6163
01-14	12/01	Recent Formulary Coverage Decisions and Drug Updates	Jaymie Mai	360-902-6792
01-13	11/01	Hospital Outpatient Prospective Payment System	Jim King	360-902-4244
01-12	11/01	Ambulatory Surgery Center Payment	Dee Hahn	360-902-6828
01-11	11/01	Transcutaneous Electrical Nerve Stimulation (TENS)	Anita Austin Susan Christiansen	360-902-6825 360-902-6821
01-09	10/01	Hearing Aid Services & Devices Reimbursement Policies & Rates	Joanne McDaniel	360-902-6817

Bulletin Number	Date Issued	Subject	Contact Person	Phone Number
01-08	8/01	Payment Policies for Attendant Services	Jim King	360-902-4244
01-07	8/01	Chiropractic Consultant Program	Joanne McDaniel	360-902-6817
01-06	6/01	Testing for and Treatment of Bloodborne Pathogens	Jamie Lifka	360-902-4941
01-05	6/01	Guidelines for Lumbar Fusion (Arthrodesis)	LaVonda McCandless	360-902-6163
01-04	5/01	Vocational Provider Performance Measurement	Mary Kaempfe	360-902-6811
01-03	5/01	Vocational Rehabilitation Payment Guidelines	Blake Maresh	360-902-6564
01-01	2/01	Vocational Rehabilitation Purchasing	Blake Maresh	360-902-6564
00-09	10/00	Recent Medical Coverage Decisions on Intradiscal Heating (IDET) and Vertebral Axial Decompression Therapy (Vax-D)	Grace Wang	360-902-5227
00-08	7/00	Utilization Review Program	Nikki D'Urso	360-902-5034
00-06	5/00	Outside of Washington State Provider Reimbursement Policies	Tom Davis Jim King	360-902-6687 360-902-4244
00-04	5/00	Payment for Opioids to Treat Chronic, Noncancer Pain	LaVonda McCandless	360-902-6163
99-11	12/99	Job Modifications and Pre-Job Accommodations	Karen Jost	360-902-5622
99-04	6/99	Physician Assistant Provider Numbers	Tom Davis	360-902-6687
99-02	5/99	Payment for Job Analysis Review	Rich Wilson	360-902-5447
98-11	12/98	Fibromyalgia	Jami Lifka	360-902-4941
98-10	12/98	Hyaluronic Acid in Treatment of Osteoarthritis of the Knee	Jami Lifka	360-902-4941
98-09	9/98	Authorizing Vocational Retraining: Policies 6.51, 6.52 & 6.53	Dave Erickson	360-902-4477
98-04	6/98	Reimbursement for Post-Acute Brain Injury Rehabilitation Treatment Programs	Jim King	360-902-4244
98-02	4/98	Post-Acute Brain Injury Rehabilitation for State Fund & Self Insured Employers	Lucille Lapalm RN, ONC	360-902-4293
98-01	2/98	Payment Policy for Nurse Case Management Services	Pat Patnode RN, ONC	360-902-5030
97-05	10/97	Complex Regional Pain Syndrome (CRPS)	LaVonda McCandless	360-902-6163
97-04	7/97	Neuromuscular Electrical Stimulation (NMES) Device	Grace Wang	360-902-5227
96-11	11/96	Home Modification Policy 11.10	Kim Skoropinski	360-902-6682
96-10	10/96	Exchanging Medical Information with Employers	Joanne McDaniel	360-902-6817
95-10	11/95	Guidelines for Electrodiagnostic Evaluation of Carpal Tunnel Syndrome	Lavonda McCandless	360-902-6163

Bulletin Number	Date Issued	Subject	Contact Person	Phone Number
95-08	10/95	Introducing the Center for Excellence for Chemically Related Illness	Joanne McDaniel	360-902-6817
95-04	4/95	Psychiatric Evaluations and Thoracic Outlet Syndrome (TOS)	LaVonda McCandless	360-902-6163
94-16	6/94	Home Health Care and Hospice Care	Lucille Lapalm RN, ONC	360-902-4293
93-02	4/93	Pain Clinics	Carole Winegar	360-902-6815

CURRENT PROVIDER UPDATE LIST

Update Number	Date Issued	Subject	Contact Person	Phone Number
03-02	12/03	Physical, Occupational and Massage Therapy	Karen Jost	360-902-5622
03-01	04/03	Transcutaneous Electrical Nerve Stimulation (TENS) Program	Anita Austin Susan Christiansen	360-902-6825 360-902-6821
02-03	12/02	Winter Voc Update	Rich Wilson	360-902-5447
02-02	11/02	Fall Voc Update	Rich Wilson	360-902-5447
02-01	5/02	Spring Voc Update	Mary Kaempfe	360-902-6811
01-02	11/01	Vocational Services	Joanne McDaniel	360-902-6817
96-02	10/96	Errors the Department Frequently Identifies during Audits and Reviews	Sharon Brosio	360-902-6299

Professional Services

This section contains payment policy information for professional services. Many of the policies contain information previously published in Provider Bulletins.

In addition to the policies outlined in this section, all providers must follow the administrative rules, medical coverage decisions and payment policies contained within the *Medical Aid Rules and Fee Schedules,* Provider Bulletins and Provider Updates. If there are any services, procedures or text contained in the CPT® and HCPCS coding books that are in conflict with the *Medical Aid Rules and Fee Schedules*, the department's rules and policies take precedence (WAC 296-20-010). All policies in this document apply to claimants receiving benefits from the State Fund, the Crime Victims Compensation Program and Self-Insurers unless otherwise noted.

Questions may be directed to the Provider Hotline at 1-800-848-0811 or to the Crime Victims Compensation Program at 1-800-762-3716.

PROFESSIONAL SERVICES TABLE OF CONTENTS

GENERAL INFORMATION

COVERED SERVICES

The department makes general policy decisions, called medical coverage decisions, to ensure quality of care and prompt treatment of workers. Medical coverage decisions include or exclude a specific health care service as a covered benefit.

Procedure codes listed as not covered in the fee schedules are not covered for the following reasons:

1. The treatment is not safe or effective; or is controversial, obsolete, investigational or experimental.
2. The procedure or service is generally not used to treat industrial injuries or occupational diseases.
3. The procedure or service is payable under another code.

The department may pay for procedures in the first two categories on a case-by-case basis. The health care provider must submit a written request and obtain approval from the department or Self-Insurer prior to performing any procedure in these categories. The written request must contain the reason for the request, the potential risks and expected benefits and the relationship to the accepted condition. The healthcare provider must provide any additional information about the procedure that may be requested by the department or Self-Insurer.

For more information on coverage decisions and covered services, refer to WAC 296-20 sections -01505, -02700 through -02850, -030, -03001, -03002 and -1102.

UNITS OF SERVICE

Payment for billing codes that do not specify a time increment or unit of measure is limited to one unit per day. For example, only one unit is payable for CPT® code 97022, whirlpool therapy, regardless of how long the therapy lasts.

UNLISTED CODES

A covered service or procedure may be provided that does not have a specific code or payment level listed in the fee schedules. When reporting such a service, the appropriate unlisted procedure code may be used and a special report is required as supporting documentation. No additional payment is made for the supporting documentation. Refer to Chapter 296-20 WAC (including the definition section) and to the fee schedules for additional information.

WASHINGTON RBRVS PAYMENT SYSTEM AND POLICIES

The department uses the Resource Based Relative Value Scale (RBRVS) to pay for most professional services. Services priced according to the RBRVS fee schedule have a fee schedule indicator of "R" in the Professional Services Fee Schedule.

BASIS FOR CALCULATING RBRVS PAYMENT LEVELS

RBRVS fee schedule allowances are based on relative value units (RVUs), geographic adjustment factors for Washington State and a conversion factor. The three state agencies (L&I, HCA and DSHS) use a common set of RVUs and geographic adjustment factors for procedures, but use different conversion factors.

The primary source for the current RVUs is the 2004 Medicare Physician Fee Schedule Database (MPFSDB), which was published by the Centers for Medicare and Medicaid Services (CMS) in the January 7, 2004 *Federal Register*. The *Federal Register* can be accessed online at http://www.gpoaccess.gov/index.html or can be purchased from the U.S. Government in hard copy, microfiche or disc formats. The *Federal Register* can be ordered from the following addresses:

Superintendent of Documents
PO Box 371954
Pittsburgh, PA 15250-7954

or http://bookstore.gpo.gov/index.html

Under CMS's approach, relative values are assigned to each procedure based on the resources required to perform the procedure, including the work, practice expense and liability insurance (malpractice expense). The state agencies geographically adjust the RVUs for each of these components based on the costs for Washington State. The Washington State geographic adjustment factors for July 1, 2004 are: 100.2% of the work component RVU, 101.1% of the practice expense RVU and 80.3% of the malpractice RVU.

To calculate the department's maximum fee for each procedure:

1. Multiply each RVU component by the corresponding geographic adjustment factor,
2. Sum the geographically adjusted RVU components and round the result to the nearest hundredth,
3. Multiply the rounded sum by the department's RBRVS conversion factor (published in WAC 296-20-135) and round to the nearest penny.

The department's maximum fees are published as dollar values in the Professional Services Fee Schedule.

SITE OF SERVICE PAYMENT DIFFERENTIAL

The site of service differential is based on CMS's payment policy and establishes distinct maximum fees for services performed in facility and non-facility settings. The department will pay professional services at the RBRVS rates for facility and non-facility settings based on where the service was performed. Therefore, it is important to **include a valid two-digit place of service code on your bill**.

The department's maximum fees for facility and non-facility settings are published in the Professional Services Fee Schedule.

Services Paid at the RBRVS Rate for Facility Settings

When services are performed in a facility setting, the department makes two payments, one to the professional provider and another to the facility. The payment to the facility includes resource costs such as labor, medical supplies and medical equipment. To avoid duplicate payment of resource costs, these costs are excluded from the RBRVS rates for facility settings.

Professional services will be paid at the RBRVS rate for facility settings when the department also makes a payment to a facility. Therefore, services billed with the following place of service codes will be paid at the rate for facility settings:

Place of Service Code	Place of Service Description
05	Indian health service free-standing facility
06	Indian health service provider-based facility
07	Tribal 638 free-standing facility
08	Tribal 638 provider-based facility
21	Inpatient hospital
22	Outpatient hospital
23	Emergency room-hospital
24	Ambulatory surgery center
25	Birthing center
26	Military treatment facility
31	Skilled nursing facility
34	Hospice
41	Ambulance (land)
42	Ambulance (air or water)
51	Inpatient psychiatric facility
52	Psychiatric facility partial hospitalization
56	Psychiatric residential treatment center
61	Comprehensive inpatient rehabilitation facility
62	Comprehensive outpatient rehabilitation facility
99	Other unlisted facility
(none)	(Place of service code not supplied)

Remember to include a valid two-digit place of service code on your bill. Bills without a place of service code will be processed at the RBRVS rate for facility settings, which could result in lower payment.

Services Paid at the RBRVS Rate for Non-Facility Settings

When services are provided in non-facility settings, the professional provider typically bears the costs of labor, medical supplies and medical equipment. These costs are included in the RBRVS rate for non-facility settings.

Professional services will be paid at the RBRVS rate for non-facility settings when the department does not make a separate payment to a facility. Therefore, services billed with the following place of service codes will be paid at the rate for non-facility settings:

Place of Service Code	Place of Service Description
03	School
04	Homeless shelter
11	Office
12	Home
13	Assisted living facility
14	Group home
15	Mobile unit
20	Urgent care facility
32	Nursing facility
33	Custodial care facility
49	Independent clinic
50	Federally qualified health center
53	Community mental health center
54	Intermediate care facility/mentally retarded
55	Residential substance abuse treatment center
57	Non-residential substance abuse treatment center
60	Mass immunization center
65	End stage renal disease treatment facility
71	State or local public health clinic
72	Rural health clinic
81	Inpatient laboratory

Facilities will be paid at the RBRVS rate for non-facility settings when the department does not make a separate payment directly to the provider of the service.

Remember to include a valid two-digit place of service code on your bill. Bills without a place of service code will be processed at the RBRVS rate for facility settings, which could result in lower payment.

EVALUATION AND MANAGEMENT SERVICES (E/M)

NEW AND ESTABLISHED PATIENT

The department uses the CPT® definitions of new and established patients.

If a patient presents with a work related condition and meets the definition of a new patient in a provider's practice, then the appropriate level of a new patient E/M should be billed.

If a patient presents with a work related condition and meets the definition of an established patient in a provider's practice, then the appropriate level of established patient E/M service should be billed, **even if the provider is treating a new work related condition for the first time.**

MEDICAL CARE IN THE HOME OR NURSING HOME

The department allows attending physicians to charge for nursing facility services (CPT® codes 99301-99313), domiciliary, rest home (e.g., boarding home), or custodial care services (CPT® codes 99321-99333) and home services (CPT® codes 99341-99350). The attending physician (not staff) must perform these services. The medical record must document the medical necessity as well as the level of service.

PROLONGED EVALUATION AND MANAGEMENT

Payment of prolonged E/M (CPT® codes 99354-99357) is allowed with a maximum of three hours per day per patient. These services are payable only when another E/M code is billed on the same day using the following CMS payment criteria:

CPT® Code	Other CPT® Code(s) Required on Same Day
99354	99201-99205, 99212-99215, 99241-99245 or 99324-99350
99355	99354 and one of the E/M codes required for 99354
99356	99221-99223, 99231-99233, 99251-99255, 99261-99263, 99301-99303 or 99311-99313
99357	99356 and one of the E/M codes required for 99356

The time counted toward payment for prolonged E/M services includes only direct face-to-face contact between the provider and the patient (whether the service was continuous or not). Prolonged physician services without direct contact (CPT® codes 99358 and 99359) are bundled and are not payable in addition to other E/M codes.

A narrative report is required when billing for prolonged evaluation and management services. See Appendix H for additional information.

PHYSICIAN STANDBY SERVICES

The department pays for physician standby services (CPT® code 99360) when all the following criteria are met:

- Another physician requested the standby service; and
- The standby service involves prolonged physician attendance without direct (face-to-face) patient contact; and
- The standby physician is not concurrently providing care or service to other patients during this period; and
- The standby service does not result in the standby physician's performance of a procedure subject to a "surgical package;" and
- Standby services of 30 minutes or more are provided.

Subsequent periods of standby beyond the first 30 minutes may be reported and are payable only when a full 30 minutes of standby was provided for each unit of service reported. Round all fractions of a 30-minute unit downward.

Justification for the physician standby service must be documented and retained in the provider's office and submitted to the department or Self-Insurer for review upon request.

A narrative report is required when billing for physician standby services.

CASE MANAGEMENT SERVICES

Team conferences (CPT® codes 99361-99362) may be payable when the attending doctor, consultant or psychologist meets with an interdisciplinary team of health professionals, department staff, vocational rehabilitation counselors, nurse case managers, department medical consultants, Self-Insurer representatives or employers. Documentation must include a goal-oriented, time-limited treatment plan covering medical, surgical, vocational or return to work activities, or objective measures of function that allow a determination as to whether a previously created plan is effective in returning the injured worker to an appropriate level of function.

Telephone calls (CPT® codes 99371-99373) are payable only when personally made by the attending doctor, consultant or psychologist. These services are payable when discussing or coordinating care or treatment with the injured worker, department staff, vocational rehabilitation counselors, nurse case managers, department medical consultants, Self-Insurer representatives or employers. Telephone calls for authorization, resolution of billing issues or ordering prescriptions are not payable.

Documentation for case management services (CPT® codes 99361-99373) must include:

- The date, and
- The participants and their titles, and
- The length of the call or visit, and
- The nature of the call or visit, and
- All medical, vocational or return to work decisions made.

Psychiatrists and clinical psychologists may only bill for case management services when also providing consultation or evaluation.

PHYSICIAN CARE PLAN OVERSIGHT

The department allows separate payment for physician care plan oversight services (CPT® codes 99375, 99378 and 99380). Payment is limited to one per attending physician, per patient, per 30-day period. Care plan services (CPT® codes 99374, 99377 and 99379) of less than 30 minutes within a 30-day period are considered part of E/M services and are not separately payable.

Payment for care plan oversight to a physician providing postsurgical care during the postoperative period will be made only if the care plan oversight is documented as unrelated to the surgery, and modifier –24 is used. The attending physician (not staff) must perform these services. The medical record must document the medical necessity as well as the level of service.

TELECONSULTATIONS

The department has adopted a modified version of CMS's policy on teleconsultations. Teleconsultations require an interactive telecommunication system, consisting of special audio and video equipment that permits real-time consultation between the patient, consultant and referring provider. Telephones, faxes and electronic mail systems do not meet the definition of an interactive telecommunication system.

Coverage of Teleconsultations

Teleconsultations are covered in the same manner as face-to-face consultations (refer to WACs 296-20-045 and –051), but in addition, **all** of the following conditions must be met:

- The **consultant** must be a doctor as described in WAC 296-20-01002, which includes a MD, DO, ND, DPM, OD, DMD, DDS or DC. A consulting DC must be an approved consultant with the department; and
- The **referring provider** must be one of the following: MD, DO, ND, DPM, OD, DMD, DDS, DC, ARNP, PA or PhD Clinical Psychologist; and
- The patient must be present at the time of the consultation; and
- The examination of the patient must be under the control of the consultant; and
- The referring provider must be physically present with the patient during the consultation; and
- The consultant must submit a written report documenting this service to the referring provider, and must send a copy to the insurer; and
- A referring provider who is not the attending must consult with the attending provider before making the referral.

Payment of Teleconsultations

Teleconsultations are paid in a different manner than face-to-face consultations. Also, the department and Self-Insurers pay for teleconsultations in a different manner than CMS. Insurers may directly pay both consultants and referring providers for their services. Insurers will pay according to the following criteria:

- Providers (consulting and/or referring) must append a "GT" modifier to one of the appropriate codes listed in the table below.
- The amount allowable for the appropriate code is the lesser of the billed amount or 75% of the fee schedule amount.
- No separate payment will be made for the review and interpretation of the patient's medical records and/or the required report that must be submitted to the referring provider and to the department.
- No payment is allowed for telephone line charges and facility fees incurred during the teleconsultation.

The Consultant May Bill Codes:	The Referring Provider May Bill Codes:
CPT® codes 99241-99245	CPT® codes 99211-99215
CPT® codes 99251-99255	CPT® codes 99218-99239
CPT® codes 99261-99263	CPT® codes 99301-99313
CPT® codes 99271-99275	CPT® codes 99331-99333
CPT® codes 99241-99244 (DCs, NDs)	CPT® codes 99347-99357
	CPT® codes 99211-99214 (for DCs, NDs)
	CPT® code 90801 (for PhD Clinical Psychologists)

END STAGE RENAL DISEASE (ESRD)

The department follows CMS's policy regarding the use of E/M services along with dialysis services. E/M services (CPT® codes 99231-99233 and 99261-99263) are not payable on the same date as hospital inpatient dialysis (CPT® codes 90935, 90937, 90945 and 90947). These E/M services are bundled in the dialysis service.

Separate billing and payment for an initial hospital visit (CPT® codes 99221-99223), an initial inpatient consultation (CPT® codes 99251-99255) and a hospital discharge service (CPT® code 99238 or 99239) will be allowed when billed on the same date as an inpatient dialysis service.

APHERESIS

The department no longer covers apheresis services. Apheresis is not used to treat industrial injuries or occupational diseases.

SURGERY SERVICES

GLOBAL SURGERY POLICY

Many surgeries have a follow-up period during which charges for normal postoperative care are bundled into the global surgery fee. The global surgery follow-up period for each surgery is listed in the "Fol-Up" column in the Professional Services Fee Schedule.

Services and Supplies Included in the Global Surgery Policy

The following services and supplies are included in the global surgery follow-up period and are considered bundled into the surgical fee:

- The operation itself.
- Preoperative visits, in or out of the hospital, beginning on the day before the surgery.
- Services by the primary surgeon, in or out of the hospital, during the postoperative period.
- Dressing changes; local incisional care and removal of operative packs; removal of cutaneous sutures, staples, lines, wires, tubes, drains and splints; insertion, irrigation and removal of urinary catheters, cast room charges, routine peripheral IV lines, nasogastric and rectal tubes; and change and removal of tracheostomy tubes. Casting materials are not part of the global surgery policy and are paid separately.
- Additional medical or surgical services required because of complications that do not require additional operating room procedures.

How to Apply the Follow-Up Period

The follow-up period applies to **any provider** who participated in the surgical procedure. These providers include:

- Surgeon or physician who performs any component of the surgery (e.g., the pre, intra and/or postoperative care of the patient; identified by modifiers –56, -54 and –55)
- Assistant surgeon (identified by modifiers –80, -81 and –82)
- Two surgeons (identified by modifier –62)
- Team surgeons (identified by modifier –66)
- Anesthesiologists and CRNAs

The follow-up period always applies to the following CPT® codes, unless modifier -24, -25, -57 or -79 is appropriately used:

E/M Codes		Ophthalmological Codes
99211-99215	99301-99303	92012-92014
99218-99220	99311-99316	
99231-99239	99331-99333	
99261-99263	99347-99350	
99291-99292		

Professional inpatient services (CPT® codes 99211-99223) are only payable during the follow-up period if they are performed on an emergency basis (i.e., they are not payable for scheduled hospital admissions).

Codes that are considered bundled are **not payable** during the global surgery follow-up period.

PRE, INTRA, OR POSTOPERATIVE SERVICES

The department or Self-Insurer will allow separate payment when different physicians or providers perform the preoperative, intraoperative or postoperative components of the surgery. The appropriate modifiers (-54, -55 or -56) must be used. The percent of the maximum allowable fee for each component is listed in the Professional Services Fee Schedule.

If different providers perform different components of the surgery (pre, intra or postoperative care), the global surgery policy applies to each provider. For example, if the surgeon performing the operation transfers the patient to another physician for the postoperative care, the same global surgery policy, including the restrictions in the follow-up day period, applies to both physicians.

MINOR SURGICAL PROCEDURES

For minor surgical procedures, the department follows CMS's policy to not allow payment for an E/M office visit during the global period unless:

- A documented, unrelated service is furnished during the postoperative period and modifier –24 is used, or
- The practitioner who performs the procedure is seeing the patient for the first time, in which case an initial new patient E/M service can be billed. This is considered a significant, separately identifiable service and modifier –25 must be used. Appropriate documentation must be made in the chart describing the E/M service.

CPT® code 99025, initial surgical evaluation, is considered bundled and is not separately payable. Modifier –57, decision for surgery, is not payable with minor surgeries. When the decision to perform the minor procedure is made immediately before the service, it is considered a routine preoperative service and a visit or consultation is not paid in addition to the procedure.

Modifier –57 is payable with an E/M service only when the visit results in the initial decision to perform major surgery.

STANDARD MULTIPLE SURGERY POLICY

When multiple surgeries are performed on the same patient at the same operative session or on the same day, the total payment equals the sum of:

100% of the global fee for the procedure or procedure group with the highest value, according to the fee schedule.

50% of the global fee for the **second through fifth procedures** with the next highest values, according to the fee schedule.

Procedures in excess of five require submission of documentation and individual review to determine payment amount.

When different types of surgical procedures are performed on the same patient on the same day for accepted conditions, the payment policies will always be applied in the following sequence:

- Multiple endoscopy procedures for endoscopy procedures
- Other modifier policies
- Standard multiple surgery policy
- When the same surgical procedure is performed on multiple levels, each level must be billed as a separate line item. See the Bilateral Procedures Policy for additional instructions on billing bilateral procedures.

BILATERAL PROCEDURES POLICY

Bilateral surgeries should be billed as two line items. Modifier –50 should be applied to the second line item. When billing for bilateral surgeries, the two line items should be treated as one procedure. The second line item is paid at the lesser of the billed charge or 50% of the fee schedule maximum.

Check the Professional Services Fee Schedule to see if modifier –50 is valid with the procedure performed.

Example: Bilateral Procedure

Line Item	CPT® Code/Modifier	Maximum Payment (non-facility setting)	Bilateral Policy Applied	Allowed Amount
1	64721	$ 499.21		$ 499.21 (1)
2	64721-50	$ 499.21	$ 249.62 (2)	$ 249.62
Total Allowed Amount in Non-Facility Setting:				$ 748.83 (3)

(1) Allowed amount for the highest valued procedure is the fee schedule maximum.
(2) When applying the bilateral payment policy, the two line items will be treated as one procedure. The second line item billed with a modifier –50 is paid at 50% of the value paid for the first line item.
(3) Represents total allowable amount.

ENDOSCOPY PROCEDURES POLICY

For the purpose of these payment policies, the term, “endoscopy” will be used to refer to any invasive procedure performed with the use of a fiberoptic scope or other similar instrument.

Payment is not allowed for an E/M office visit (CPT® codes 99201-99215) on the same day as a diagnostic or surgical endoscopic procedure unless a documented, separately identifiable service is provided and modifier –25 is used.

Endoscopy procedures are grouped into clinically related “families.” Each endoscopy family contains a “base” procedure that is generally defined as the diagnostic procedure (as opposed to a surgical procedure).

The base procedure for each code belonging to an endoscopy family is listed in the “Endo Base” column in the Professional Services Fee Schedule. Base procedures and their family members are also identified in **Appendix A**, “Endoscopy Families.”

When multiple endoscopy procedures belonging to the same family (related to the same base procedure) are billed, maximum payment is calculated as follows:

1. Maximum payment for the endoscopy procedure with the highest dollar value listed in the fee schedule is 100% of the fee schedule value.
2. For subsequent endoscopy procedures, maximum payment is calculated by subtracting the fee schedule maximum for the base procedure from the fee schedule maximum for the endoscopy family member.
3. When the fee schedule maximum for a family member is less than that of the base code, no add-on will be provided nor will there be a reduction in payment. Consider the portion of payment for this family member equal to $0.00 (see example 2).
4. No additional payment is made for a base procedure when a family member is billed.

Once payment for all endoscopy procedures is calculated, each family is defined as an "endoscopic group." If more than one endoscopic group or other non-endoscopy procedure is billed for the same patient on the same day by the same provider, the standard multiple surgery policy will be applied to all procedures (see example 3).

Multiple endoscopies that are not related (e.g., each is a separate and unrelated procedure) are priced as follows:

1. 100% for each unrelated procedure, then
2. Apply the standard multiple surgery policy

Example 1: Two Endoscopy Procedures in the Same Family

Line Item	CPT® Code	Maximum Payment (non-facility setting)	Endoscopy Policy Applied	Allowed Amount
Base (1)	29870	$ 535.16	$ 000.00 (2)	
1	29874	$ 705.28	$ 170.12 (4)	$ 170.12 (5)
2	29880	$ 858.18	$ 858.18 (3)	$ 858.18 (5)
			Total Allowed Amount in Non-Facility Setting:	$ 1028.30 (6)

(1) Base code listed is for reference only (not included on bill form).
(2) Payment is not allowed for a base code when a family member is billed.
(3) Allowed amount for the highest valued procedure in the family is the fee schedule maximum.
(4) Allowed amount for other procedures in the same endoscopy family is calculated by subtracting the fee schedule maximum for the base code from the fee schedule maximum for the non-base code.
(5) Amount allowed under the endoscopy policy.
(6) Represents total allowed amount after applying all applicable global surgery policies. Standard multiple surgery policy does not apply because only one family of endoscopic procedures was billed.

Example 2: Endoscopy Family Member With Fee Less than Base Procedure

Line Item	CPT® Code	Maximum Payment (non-facility setting)	Endoscopy Policy Applied	Allowed Amount
Base (1)	43235	$ 385.30		
1	43241	$ 196.44	$ 000.00 (3)	
2	43251	$ 274.92	$ 274.92 (2)	$ 274.92 (4)
			Total Allowed Amount in Non-Facility Setting:	$ 274.92 (5)

(1) Base code listed is for reference only (not included on bill form).
(2) Allowed amount for the highest valued procedure in the family is the fee schedule maximum.
(3) When the fee schedule maximum for a code in an endoscopy family is less than the fee schedule maximum for the base code, no add-on will be provided nor will there be a reduction in payment. Consider the portion of payment for the lesser family member equal to $0.00.
(4) Allowed amount under the endoscopy policy.
(5) Represents total allowed amount. Standard multiple surgery policy does not apply because only one endoscopic group was billed.

Example 3: Two Surgical Procedures Billed with an Endoscopic Group

Line Item	CPT® Code	Maximum Payment (non-facility setting)	Endoscopy Policy Applied	Standard Multiple Surgery Policy Applied
1	11402	$ 197.46		$ 98.73 (5)
2	11406	$ 310.87		$ 155.44 (5)
Base (1)	29830	$ 598.95		
3	29835	$ 666.80	$ 67.85 (3)	$ 67.85 (4)
4	29838	$ 789.32	$ 789.32 (2)	$ 789.32 (4)
Total Allowed Amount in Non-Facility Setting:				$ 1111.34 (6)

(1) Base code listed is for reference only (not included on bill form).
(2) Allowed amount for the highest valued arthroscopy procedure is the fee schedule maximum.
(3) Allowed amount for the second highest valued arthroscopy procedure in the family is calculated by subtracting the fee schedule maximum for the base code from the fee schedule maximum for the non-base code.
(4) Standard multiple surgery policy is applied, with the highest valued surgical procedure or procedure group being paid at 100%.
(5) Standard multiple surgery policy is applied, with the second and third highest valued surgical procedures being paid at 50% each.
(6) Represents total allowed amount after applying all applicable global surgery policies.

MICROSURGERY

CPT® code 69990 is an "add-on" surgical code that indicates an operative microscope has been used. As an "add-on" code, it is not subject to multiple surgery rules.

CPT® code 69990 is not payable when:

- Using magnifying loupes or other corrected vision devices, or
- Use of the operative microscope is an inclusive component of the procedure, (i.e., the procedure description specifies that microsurgical techniques are used), or
- Another code describes the same procedure being done with an operative microscope. For example, CPT® code 69990 may not be billed with CPT® code 31535, operative laryngoscopy, because CPT® code 31536 describes the same procedure using an operating microscope. The table below contains a complete list of all such codes.

CPT® Codes Not Allowed with CPT® 69990

CPT®Code	CPT®Code	CPT®Code	CPT®Code
15756-15758	26551-26554	31540-31541	61548
15842	26556	31560-31561	63075-63078
19364	31520	31570-31571	64727
19368	31525-31526	43116	64820-64823
20955-20962	31530-31531	43496	65091-68850
20969-20973	31535-31536	49906	

SPINAL INJECTION POLICY

Injection procedures are divided into three categories:

1. Injection procedures that require fluoroscopy.
2. Injection procedures that may be done without fluoroscopy when performed at a certified or accredited facility by a physician with privileges to perform the procedure at that facility. These procedures require fluoroscopy if they are not performed at a certified or accredited facility.
3. Injection procedures that do not require fluoroscopy.

Definition of Certified or Accredited Facility

The department defines a certified or accredited facility as a facility or office that has certification or accreditation from one of the following organizations:

1. Medicare (CMS - Centers for Medicare and Medicaid Services)
2. Joint Commission on Accreditation of Healthcare Organizations (JCAHO)
3. Accreditation Association for Ambulatory Health Care (AAAHC)
4. American Association for Accreditation of Ambulatory Surgical Facilities (AAAASF)
5. American Osteopathic Association (AOA)
6. Commission on Accreditation of Rehabilitation Facilities (CARF)

Spinal Injection Procedures that Require Fluoroscopy

CPT® Code	Abbreviated CPT® Code Description	CPT® Fluoroscopy Codes(1),(2)
62268	Drain spinal cord cyst	76003, 76360, 76942
62269	Needle biopsy, spinal cord	76003, 76360, 76942
62281	Treat spinal cord lesion	76005, 72275
62282	Treat spinal cord canal	76005, 72275
62284	Injection for myelogram or CT scan	76005, 76360, 76942, 72240, 72255, 72265, 72270
62290	Inject for spine disk x-ray	72295
62291	Inject for spine disk x-ray	72285
62292	Injection for disk lesion	72295
62294	Injection into spinal artery	76003, 76005, 76360, 75705
62310	Inject spine c/t	76005, 72275
62311	Inject spine l/s (cd)	76005, 72275
62318	Inject spine w/cath, c/t	76005, 72275
62319	Inject spine w/cath l/s (cd)	76005, 72275
64470	Inject paravertebral c/t	76005
64472	Inject paravertebral c/t add-on	76005
64475	Inject paravertebral l/s	76005
64476	Inject paravertebral l/s add-on	76005
64479	Inject foramen epidural c/t	76005, 72275
64480	Inject foramen epidural add-on	76005, 72275
64483	Inject foramen epidural l/s	76005, 72275
64484	Inject foramen epidural add-on	76005, 72275

(1) One of the indicated fluoroscopy codes must be billed along with the underlying procedure code or the bill for the underlying procedure will be denied.

(2) Only one of the indicated fluoroscopy codes may be billed for each injection.

Spinal Injection Procedures that May Be Done Without Fluoroscopy

Interlaminar epidural steroid injections may be performed without fluoroscopy if performed at a certified or accredited facility by a physician with privileges to perform the procedure at that facility. The physician must decide whether to use fluoroscopy based on sound medical practice.

To be payable, these spinal injections must include a facility place of service code and documentation that the procedure was performed at a certified or accredited facility.

CPT® Code	Abbreviated CPT® Code Description
62310	Inject spine c/t
62311	Inject spine l/s (cd)
62318	Inject spine w/cath, c/t
62319	Inject spine w/cath l/s (cd)

Spinal Injection Procedures that Do Not Require Fluoroscopy

CPT® Code	Abbreviated CPT® Code Description
62270	Spinal fluid tap diagnostic
62272	Drain spinal fluid
62273	Treat epidural spine lesion

Payment Methods for Spinal Injection Procedures

Provider Type	Procedure Type	Payment Method
Physician or CRNA/ARNP	Injection	-26 Component of Professional Services Fee Schedule
	Radiology	-26 Component of Professional Services Fee Schedule
Radiology Facility	Injection	No Facility Payment
	Radiology	-TC Component of Professional Services Fee Schedule
Hospital(1)	Injection	APC or POAC
	Radiology(2)	APC or -TC Component of Professional Services Fee Schedule
ASC	Injection	ASC Fee Schedule
	Radiology	-TC Component of Professional Services Fee Schedule

(1) Payment method depends on a hospital's classification.
(2) Radiology codes may be packaged with the injection procedure.

REGISTERED NURSES AS SURGICAL ASSISTANTS

Licensed registered nurses may perform surgical assistant services if the registered nurse submits the following documents to the department or Self-Insurer along with a completed provider application.

1. A photocopy of her or his valid and current registered nurse license, and
2. A letter granting on-site hospital privileges for **each** institution where surgical assistant services will be performed.

Payment for these services is 90% of the allowed fee that would otherwise be paid to an assistant surgeon.

PROCEDURES PERFORMED IN A PHYSICIAN'S OFFICE

Modifier –SU denotes the use of facility and equipment while performing a procedure in a physician's office.

Modifier –SU is not covered and the department will not make a separate facility payment. Procedures performed in a physician's office are paid at nonfacility rates that include office expenses.

Physicians' offices must meet ASC requirements to qualify for separate facility payments. Refer to Chapter 296-23B WAC for information about the requirements.

MISCELLANEOUS

Angioscopy

Payment for angioscopies (CPT® code 35400) is limited to only one unit based on its complete code description encompassing multiple vessels. The work involved with varying numbers of vessels was incorporated in the RVUs.

Autologous Chondrocyte Implant

The department or Self-Insurer may cover autologous chondrocyte implant (ACI) when all of the guidelines outlined in Provider Bulletin 03-02, *Coverage Decisions*, are met. ACI requires prior authorization.

In addition to the clinical guidelines for the procedure, the surgeon must have received training through Genzyme Biosurgery and have performed or assisted with 5 ACI procedures or perform ACI under the direct supervision and control of a surgeon who has performed 5 or more ACI procedures.

If the procedure is authorized, the department will pay Genzyme Biosurgery directly for Carticel® (autologous cultured chondrocytes). For more information, go to http://www.LNI.wa.gov/ClaimsInsurance/Providers/ProviderBulletins/default.asp.

Bone Morphogenic Protein

The department may cover the use of bone morphogenic protein as an alternative to autograft in recalcitrant long bone nonunion where use of autograft is not feasible and alternative treatments have failed. It may also cover its use for spinal fusions in patients with degenerative disc disease at one level from L4-S1.

All of the criteria and guidelines outlined in Provider Bulletin 04-01, *Coverage Decisions, July 2003 to December 2003* must be met before the department will authorize the procedures. For more information, go to http://www.LNI.wa.gov/ClaimsInsurance/Providers/ProviderBulletins/default.asp.

In addition lumbar fusion guidelines must be met. Information about the guidelines can be found at http://www.LNI.wa.gov/ClaimsInsurance/Providers/TreatmentGuidelines/MedPub/default.asp.

Closure of Enterostomy

Closures of enterostomy (CPT® codes 44625 and 44626) are not payable with mobilization (take down) of splenic flexure performed in conjunction with partial colectomy (CPT® code 44139). CPT® code 44139 will be denied if it is billed with CPT® code 44625 or 44626.

Meniscal Allograft Transplantation

The department or Self-Insurer may cover meniscal allograft transplantation when all of the guidelines outlined in Provider Bulletin 03-02, Coverage Decisions, are met. Meniscal allograft transplantation requires prior authorization.

In addition to the clinical guidelines for the procedure, the surgeon must have performed or assisted with 5 meniscal allograft transplants or perform the transplant under the direct supervision and control of a surgeon who has performed 5 or more transplants. For more information, go to http://www.LNI.wa.gov/ClaimsInsurance/Providers/ProviderBulletins/default.asp.

ANESTHESIA SERVICES

Anesthesia payment policies are established by the department with input from the RSC and the Anesthesia Technical Advisory Group (ATAG). The RSC is a standing committee with representatives from L&I, DSHS and HCA. The ATAG includes anesthesiologists, CRNAs and billing professionals.

NON-COVERED AND BUNDLED SERVICES

Anesthesia Assistant Services

The department does not cover anesthesia assistant services.

Non-Covered Procedures

Anesthesia is not payable for procedures that are not covered by the department. Refer to **Appendix D** for a list of non-covered procedures.

Patient Acuity

Patient acuity does not affect payment levels. Payment for qualifying circumstances (CPT® codes 99100, 99116, 99135 and 99140) is considered bundled and is not payable separately. CPT® physical status modifiers (-P1 to -P6) and CPT® five-digit modifiers are not accepted.

Anesthesia by Surgeon

Payment for local, regional or digital block, or general anesthesia administered by the surgeon is included in the RBRVS payment for the procedure. Services billed with modifier -47 (anesthesia by surgeon) are considered bundled and are not payable separately.

CERTIFIED REGISTERED NURSE ANESTHETISTS (CRNA)

CRNA services are paid at a maximum of 90% of the allowed fee that would otherwise be paid to a physician.

Refer to WAC 296-23-240 for licensed nursing rules and 296-23-245 for licensed nursing billing instructions. For more detailed billing instructions, including examples of how to submit bills, refer to the department's HCFA-1500 billing instructions (publication F248-094-000).

CRNA services should not be reported on the same HCFA-1500 form used to report anesthesiologist services; this applies to solo CRNA services as well as team care.

MEDICAL DIRECTION OF ANESTHESIA (TEAM CARE)

The department follows CMS's policy for medical direction of anesthesia (team care).

Requirements for Medical Direction of Anesthesia

Physicians directing qualified individuals performing anesthesia must:

- Perform a pre-anesthetic examination and evaluation, and
- Prescribe the anesthesia plan, and
- Personally participate in the most demanding aspects of the anesthesia plan, including, if applicable, induction and emergence, and
- Ensure that any procedures in the anesthesia plan that he or she does not perform are performed by a qualified individual as defined in program operating instructions, and
- Monitor the course of anesthesia administration at frequent intervals, and
- Remain physically present and available for immediate diagnosis and treatment of emergencies, and
- Provide indicated post-anesthesia care.

In addition, physicians directing anesthesia:

- May direct no more than four anesthesia services concurrently, and
- May not perform any other services while directing the single or concurrent services.

The physician may attend to medical emergencies and perform other limited services as allowed by Medicare instructions and still be deemed to have medically directed anesthesia procedures.

Documentation Requirements for Team Care

The physician must document in the patient's medical record that the medical direction requirements were met. The physician does not need to submit this documentation with the bill, but must make the documentation available to the insurer upon request.

Billing for Team Care

When billing for team care situations:

- Anesthesiologists and CRNAs must report their services on separate HCFA-1500 forms using their own provider account numbers.
- Anesthesiologists must use the appropriate modifier for medical direction or supervision (-QK or -QY).
- CRNAs should use modifier -QX.

Payment for Team Care

To determine the maximum payment for team care services:

- Calculate the maximum payment for solo physician services.
  (Refer to Anesthesia Payment Calculation in the Anesthesia Services Paid with Base and Time Units section.)
- The maximum payment to the physician is 50% of the maximum payment for solo physician services.
- The maximum payment to the CRNA is 45% of the maximum payment for solo physician services (90% of the other 50% share).

ANESTHESIA SERVICES PAID WITH BASE AND TIME UNITS

Most anesthesia services are paid with base and time units. These services should be billed with CPT® anesthesia codes 00100 through 01999 and the appropriate anesthesia modifier.

Anesthesia Base Units

Most of the department's anesthesia base units are the same as the 2003 anesthesia base units adopted by CMS. The department diverges from the CMS base units for some procedure codes based on input from the ATAG. The anesthesia codes, base units and base sources are listed in the Professional Services Fee Schedule.

Anesthesia Time

Anesthesia time begins when the anesthesiologist or CRNA starts to physically prepare the patient for the induction of anesthesia in the operating room area (or its equivalent).

Anesthesia time ends when the anesthesiologist or CRNA is no longer in constant attendance (i.e., when the patient can be safely placed under postoperative supervision). Anesthesia must be billed in one-minute time units.

List only the time in minutes on your bill. Do not include the base units. The appropriate base units will be automatically added by the department's payment system when the bill is processed.

Anesthesia Modifiers

Anesthesiologists and CRNAs should use the modifiers in this section when billing for anesthesia services paid with base and time units. With the exception of modifier –99, these modifiers are not valid for anesthesia services paid by the RBRVS method.

Services billed with CPT® five-digit modifiers and physical status modifiers (P1 through P6) will not be paid. Refer to a current CPT® or HCPCS book for complete modifier descriptions and instructions.

CPT® Modifier

For Use By	Modifier	Brief Description	Notes
Anesthesiologists and CRNAs	-99	Multiple modifiers	Use this modifier when five or more modifiers are required. Enter –99 in the modifier column on the bill. List individual descriptive modifiers elsewhere on the billing document.

HCPCS Modifiers

For Use By	Modifier	Brief Description	Notes
Anesthesiologists	-AA	Anesthesia services performed personally by anesthesiologist	
	-QK	Medical direction of two, three, or four concurrent anesthesia procedures involving qualified individual	Payment based on policies for team services.
	- QY	Medical direction of one CRNA for a single anesthesia procedure	Payment based on policies for team services.
CRNAs*	-QX	CRNA service: with medical direction by a physician	Payment based on policies for team services.
	-QZ	CRNA service: without medical direction by a physician	Maximum payment is 90% of the maximum allowed for physician services.

* Bills from CRNAs that do not contain a modifier are paid based on payment policies for team services.

Anesthesia Payment Calculation

The maximum payment for anesthesia services paid with base and time units is calculated using the base value for the procedure, the time the anesthesia service is administered and the department's anesthesia conversion factor.

The anesthesia conversion factor is published in WAC 296-20-135. For services provided on or after July 1, 2004, the anesthesia conversion factor is $42.15 per 15 minutes ($2.81 per minute). Providers are paid the lesser of their charged amount or the department's maximum allowed amount.

To determine the maximum payment for physician services:

1. Multiply the base units listed in the fee schedule by fifteen.
2. Add the value from step 1 to the total number of whole minutes.
3. Multiply the result from step 2 by $2.81.

The maximum payment for services provided by a CRNA is 90% of the maximum payment for a physician.

Example: CPT® code 01382 (anesthesia for knee arthroscopy) has 3 anesthesia base units. If the anesthesia service takes 60 minutes, the maximum physician payment would be calculated as follows:

1. Base units x 15 = 3 x 15 = 45 base units,
2. 45 base units + 60 time units (minutes) = 105 base and time units,
3. Maximum payment for physicians = 105 x $ 2.81 = $ 295.05

ANESTHESIA ADD-ON CODES

Anesthesia add-on codes should be billed with a primary anesthesia code. There are three anesthesia add-on codes in the 2003 CPT® book: 01953, 01968 and 01969. CPT® add-on code 01953 should be billed with primary code 01952. CPT® add-on codes 01968 and 01969 should be billed with primary code 01967.

Anesthesia add-on codes 01968 and 01969 should be billed in the same manner as other anesthesia codes paid with base and time units. Providers should report the total time for the add-on procedure (in minutes) in the "Units" column (Field 24G) of the HCFA-1500 form.

Anesthesia for Burn Excisions or Debridement

The anesthesia add-on code for burn excision or debridement, CPT® code 01953, must be billed according to the instructions in the following table.

Total Body Surface Area	Primary Code	Units of Add-On Code 01953
Less than 1 percent	01951	None
1 - 9 percent	01952	None
Up to 18 percent	01952	1
Up to 27 percent	01952	2
Up to 36 percent	01952	3
Up to 45 percent	01952	4
Up to 54 percent	01952	5
Up to 63 percent	01952	6
Up to 72 percent	01952	7
Up to 81 percent	01952	8
Up to 90 percent	01952	9
Up to 99 percent	01952	10

ANESTHESIA SERVICES PAID BY THE RBRVS METHOD

Some services commonly performed by anesthesiologists and CRNAs are not paid with anesthesia base and time units. These services include anesthesia CPT® code 01996, evaluation and management services, most pain management services and other selected services. These services paid by the RBRVS payment method and are listed in **Appendix F**.

Modifiers

Anesthesia modifiers -AA, -QK, -QX, -QY and -QZ are not valid for services paid by the RBRVS method.

Refer to a current CPT® or HCPCS book for a complete list of modifiers and descriptions. Refer to **Appendix E** for a list of modifiers that affect payment.

Maximum Payment

Maximum fees for services paid by the RBRVS method are located in the Professional Services Fee Schedule.

When billing for services paid with the RBRVS method, enter the total number of times the procedure is performed, not the total minutes, in the "Units" column (Field 24G on the HCFA-1500 bill form).

E/M Services Payable with Pain Management Procedures

An E/M service is payable on the same day as a pain management procedure only when:

- It is the patient's initial visit to the practitioner who is performing the procedure, or
- The E/M service is clearly separate and identifiable from the pain management procedure performed on the same day, and meets the criteria for an E/M service.

The office notes or report must document the objective and subjective findings used to determine the need for the procedure and any future treatment plan or course of action. The use of E/M codes on days after the procedure is performed is subject to the global surgery policy (refer to the Surgery Services section).

Injection Code Treatment Limits

Details regarding treatment guidelines and limits for the following kinds of injections can also be found in WAC 296-20-03001. Refer to Medication Administration in the Other Medicine Services section for information on billing for medications.

Injection	Treatment Limit
Epidural and caudal injections of substances other than anesthetic or contrast solution	**Maximum of six** injections per acute episode are allowed.
Facet injections	**Maximum of four** injection procedures per patient are allowed.
Intramuscular and trigger point injections of steroids and other non-scheduled medications and trigger point dry needling(1)	**Maximum of six** injections per patient are allowed.

(1) Dry needling is considered a variant of trigger point injections with medications. It is a technique where needles are inserted (no medications are injected) directly into trigger point locations as opposed to the distant points or meridians used in acupuncture. The department does not cover acupuncture services (WAC 296-20-03002). Dry needling of trigger points should be billed using trigger point injection codes 20552 or 20553. Dry needling follows the same rules as trigger point injections in WAC 296-20-03001(14).

RADIOLOGY

X-RAY SERVICES

Repeat X-Rays

No payment will be made for excessive or unnecessary x-rays. Repeat or serial x-rays may be performed only upon adequate clinical justification to confirm changes in the accepted condition(s) when need is supported by documented changes in objective findings or subjective complaints.

Number of Views

There is no code that is specific for additional views for radiology services. Therefore, the number of views of x-rays that may be paid is determined by the CPT® description for the particular service.

For example, the following CPT® codes for radiologic exams of the spine are payable as outlined below:

CPT® Code	Payable
72020	Once for a single view
72040	Once for two to three views
72050	Once for four or more views
72052	Once, regardless of the number of views it takes to complete the series

-RT and –LT Modifiers

HCPCS modifiers –RT (right side) and –LT (left side) do not affect payment, but may be used with CPT® radiology codes 70010-79999 to identify duplicate procedures performed on opposite sides of the body.

Portable X-Rays

Radiology services furnished in the patient's place of residence are limited to the following tests, which must be performed under the general supervision of a physician:

- Skeletal films involving extremities, pelvis, vertebral column or skull
- Chest or abdominal films that do not involve the use of contrast media
- Diagnostic mammograms

HCPCS codes for transportation of portable x-ray equipment R0070 (one patient) or R0075 (multiple patients) may be paid in addition to the appropriate radiology code(s).

Custody

X-rays must be retained for ten years. See WACs 296-20-121 and 296-23-140(1).

CONSULTATION SERVICES

CPT® code 76140, x-ray consultation, is not covered. For radiology codes where a consultation service is performed, providers must bill the specific x-ray code with the modifier –26. For example, if a consultation is made on a chest x-ray, single view, frontal, the provider would bill CPT® code 71010-26.

Separate payment will not be made for review of films taken previously or elsewhere if a face-to-face service is performed on the same date as the x-ray review. Review of records and diagnostic studies is bundled into the E/M, chiropractic care visit or other procedure(s) performed.

Payment for a radiological consultation will be made at the established professional component (modifier –26) rate for each specific radiology service. A written report of the radiology consultation is required.

CONTRAST MATERIAL

Separate payment will not be made for contrast material unless a patient requires low osmolar contrast media (LOCM). LOCM may be used in intrathecal, intravenous and intra-arterial injections for patients with one or more of the following conditions:

- A history of previous adverse reaction to contrast material, with the exception of a sensation of heat, flushing, or a single episode of nausea or vomiting,
- A history of asthma or allergy,
- Significant cardiac dysfunction including recent imminent cardiac decompensation, arrhythmias, unstable angina pectoris, recent myocardial infarction and pulmonary hypertension,
- Generalized severe debilitation, or
- Sickle cell disease.

To bill for LOCM, use the appropriate HCPCS code, A4644, A4645 or A4646. The brand name of the LOCM and the dosage must be documented in the patient's chart. HCPCS codes and payment levels are listed in the Professional Services Fee Schedule.

HCPCS codes A4644, A4645 and A4646 are paid at a flat rate based on the AWP per ml. Bill one unit per ml. A9525, Low/iso-osmolar contrast mat, is not a valid code for LOCM.

NUCLEAR MEDICINE

The standard multiple surgery policies apply to the following radiology codes for nuclear medicine services.

CPT® Code	Abbreviated Description
78306	Bone imaging, whole body
78320	Bone imaging (3D)
78802	Tumor imaging, whole body
78803	Tumor imaging (3D)
78806	Abscess imaging, whole body
78807	Nuclear localization/abscess

The multiple procedures reduction will be applied when these codes are billed:

- With other codes that are subject to the standard multiple surgery policy, and
- For the same patient, on the same day, by the same physician or by more than one physician of the same specialty in the same group practice.

Refer to the Surgery Services section for more information about the standard multiple surgery payment policies.

PHYSICAL MEDICINE

GENERAL INFORMATION

Units of Service

Supervised modalities and therapeutic procedures that do not list a specific time increment in their description are limited to one unit per day.

Non-Covered and Bundled Codes

The following physical medicine codes are not covered:

Code	Abbreviated Description
CPT® 97005	Athletic train eval
CPT® 97006	Athletic train reeval
CPT® 97545(1)	Work hardening
CPT® 97546(1)	Work hardening add-on
CPT® 97033	Electric current therapy
CPT® 97781	Acupuncture w/stimul

(1) Work hardening services are paid with local codes. See Work Hardening and Work Conditioning later in this section.

The following are examples of bundled items or services:

- CPT® code 97010, application of hot or cold packs
- Ice packs, ice caps and collars
- Electrodes and gel
- Activity supplies used in work hardening, such as leather and wood
- Exercise balls
- Thera-taping
- Wound dressing materials used during an office visit and/or physical therapy treatment

Refer to the appendices for complete lists of non-covered and bundled codes.

PHYSICAL CAPACITIES EVALUATION

The following local code is payable only to physicians who are board qualified or certified in physical medicine and rehabilitation, and physical and occupational therapists.

1045M Performance-based physical capacities evaluation with report and summary of capacities ..... $ 622.33

PHYSICAL MEDICINE AND REHABILITATION (PHYSIATRY)

Medical or Osteopathic physicians who are board qualified or board certified in physical medicine and rehabilitation may be paid for CPT® codes 97001 through 97799. CPT® code 64550, apply neurostimulator (TENS), is payable only once per claim.

NON-BOARD CERTIFIED/QUALIFIED PHYSICAL MEDICINE PROVIDERS

Special payment policies apply for attending doctors who are not board qualified or certified in physical medicine and rehabilitation:

- Attending doctors who are not board qualified or certified in physical medicine and rehabilitation will not be paid for CPT® codes 97001-97799. They may perform physical medicine modalities and procedures described in CPT® codes 97001-97750 if their scope of practice and training permit it, but must bill local code 1044M for these services.

- Local code 1044M is limited to six visits per claim, except when the attending doctor practices in a remote location where no licensed, registered physical therapist is available.
- After six visits, the patient must be referred to a licensed, registered physical therapist or physiatrist for such treatment. Refer to WAC 296-21-290 for more information.

1044M Physical medicine modality(ies) and/or procedure(s) by attending doctor who is not board qualified or certified in physical medicine and rehabilitation. Limited to first six visits except when doctor practices in a remote area. ..... $ 37.97

PHYSICAL AND OCCUPATIONAL THERAPY

Physical and occupational therapy services must be ordered by the worker's attending doctor.

Physical therapy services must be provided by a licensed physical therapist or a physical therapist assistant serving under the direct supervision of a registered physical therapist (see WAC 296-23-220).

Occupational therapy services must be provided by a licensed occupational therapist or occupational therapist assistant serving under the direction of a licensed occupational therapist (see WAC 296-23-230).

Billing Codes

Physical and occupational therapists must use the appropriate physical medicine CPT® codes 97001-97799, with the exceptions noted later in this section. In addition, physical and occupational therapists must bill the appropriate covered HCPCS codes for miscellaneous materials and supplies. For information on surgical dressings dispensed for home use, refer to the Supplies, Materials and Bundled Services section.

If more than one patient is treated at the same time in a group setting, use CPT® code 97150, group therapeutic procedures.

Daily Maximum for Services

The daily maximum allowable fee for physical and occupational therapy services (see WAC 296-23-220 and WAC 296-23-230)…..... $104.12

The daily maximum applies to CPT® codes 64550 and 97001-97799 when performed for the same patient for the same date of service. If both physical and occupational therapy services are provided on the same day, the daily maximum applies once for each provider type.

The daily maximum allowable fee does not apply to performance based physical capacities examinations (PCEs), work hardening services, work evaluations or job/pre-job accommodation consultation services.

Physical and Occupational Therapy Evaluations

Physical and occupational therapy evaluations must be billed with CPT® codes 97001 through 97004 according to the table below.

Provider	Initial Evaluation	Reevaluation
Physician or Physical Therapist	CPT® 97001	CPT® 97002
Physician or Occupational Therapist	CPT® 97003	CPT® 97004

CPT® codes 97001 and 97003 are used to report the initial evaluation before the plan of care is established by the physician or therapist. The purpose of the initial evaluation is to evaluate the patient's condition and establish a plan of care.

CPT® codes 97002 and 97004 are used to report the reevaluation of a patient who has been under a plan of care established by the physician or therapist. This evaluation is for the purpose of re-evaluating the patient's condition and revising the plan of care under which the

patient is being treated. There is no limit as to how frequently CPT® codes 97002 and 97004 can be billed.

Wound Debridement

Therapists may not bill the surgical CPT® codes for wound debridement. Therapists must bill CPT® 97601 or 97602 when performing wound debridement that exceeds what is incidental to a therapy (e.g., whirlpool).

Wound dressings and supplies used in the office are bundled and are not separately payable. Wound dressings and supplies sent home with the patient for self-care can be billed with HCPCS codes appended with local modifier -1S. See the Supplies, Materials and Bundled Services section for more information.

MASSAGE THERAPY

Massage therapists must bill CPT® code 97124 for all forms of massage therapy, regardless of the technique used. The department will not pay massage therapists for additional codes.

Massage therapists must bill their usual and customary fee and designate the duration of the massage therapy treatment.

Massage is a physical medicine service and is subject to the daily maximum allowable amount of ..... $104.12.

The application of hot or cold packs (CPT® code 97010), anti-friction devices and lubricants (e.g., oils, lotions, emollients, etc.) are bundled into the massage therapy service and are not payable separately. Refer to WAC 296-23-250 for additional information.

Massage therapy services must be billed in 15-minute time increments. Bill one unit of CPT® code 97124 for each 15 minutes of massage therapy.

PHYSICAL MEDICINE CPT® CODES BILLING GUIDANCE

The following provides guidance regarding the use of CPT® codes 97032-97036, 97110-97124, 97140, 97504-97542 and 97703-97755.

Timed Codes

Several CPT® codes used for therapy modalities, procedures and tests and measurements specify that the direct (one on one) time spent in patient contact is 15 minutes. Providers report procedure codes for services delivered on **any calendar day** using CPT® codes and the appropriate number of units of service. For any single CPT® code, providers bill a single 15-minute unit for treatment greater than or equal to 8 minutes and less than 23 minutes. If the duration of a single modality or procedure is greater than or equal to 23 minutes to less than 38 minutes, then 2 units should be billed. Time intervals for larger numbers of units are as follows:

Units Reported on the Claim	Number Minutes
3 units	> 38 minutes to < 53 minutes
4 units	> 53 minutes to < 68 minutes
5 units	> 68 minutes to < 83 minutes
6 units	> 83 minutes to < 98 minutes
7 units	> 98 minutes to < 113 minutes
8 units	> 113 minutes to < 128 minutes

If more than one CPT® code is billed during a calendar day, then the total number of units that can be billed is constrained by the total treatment time.

- Example 1: If 24 minutes of CPT® code 97112 and 23 minutes of CPT® code 97110 were furnished, then the total treatment time was 47 minutes; so only 3 units can be billed for the treatment. The correct coding is 2 units of CPT® code 97112 and one unit of CPT® code 97110, assigning more units to the service that took the most time.
- Example 2: If a therapist delivers 5 minutes of CPT® code 97035 (ultrasound), 6 minutes of CPT® code 97140 (manual techniques), and 10 minutes of CPT® code 97110 (therapeutic exercise), then the total minutes are 21 and only one unit can be paid. Bill one unit of CPT® code 97110 (the service with the longest time time) and the clinical record will serve as documentation that the other two services were also performed.

NOTE: The above schedule of times is intended to provide assistance in rounding time into 15-minute increments. It does not imply that any minute until the eighth should be excluded from the total count. The timing of active treatment counted includes all direct treatment time.

In the same 15-minute (or other) time period, a therapist cannot bill any of the following pairs of CPT® codes for outpatient therapy services provided to the same, or to different patients. Examples include:

- Any two CPT® codes for “therapeutic procedures” requiring direct one-on-one patient contact (CPT® codes 97110-97542)
- Any two CPT® codes for modalities requiring “constant attendance” and direct one-on-one patient contact (CPT® codes 97032-97039)
- Any two CPT® codes requiring either constant attendance or direct one-on-one patient contact—as described above—(CPT® codes 97032-97542). For example: any CPT® codes for a therapeutic procedure (e.g., CPT® code 97116-gait training) with any attended modality CPT® code (e.g., CPT® code 97035-ultrasound)
- Any CPT® code for therapeutic procedures requiring direct one-on-one patient contact (CPT® codes 97110-97542) with the group therapy CPT® code 97150 requiring constant

attendance. For example: group therapy (CPT® code 97150) with neuromuscular reeducation (CPT® code 97112)

- Any CPT® code for modalities requiring constant attendance (CPT® codes 97032-97039) with the group therapy (CPT® code 97150). For example: group therapy (CPT® code 97150) with ultrasound (CPT® code 97035)
- Any untimed evaluation or reevaluation code (CPT® codes 97001-97004) with any other timed or untimed CPT® codes, including constant attendance modalities (CPT® codes 97032-97039), therapeutic procedures (CPT® codes 97110-97542) and group therapy (CPT® code 97150)

Determining What Time Counts Towards 15-Minute Timed Codes

Providers report the code for the time actually spent in the delivery of the modality requiring constant attendance and therapy services. Pre- and post-delivery services are not to be counted in determining the treatment service time. In other words, the time counted as "intra-service care" begins when the therapist or physician (or an assistant under the supervision of a physician or therapist) is directly working with the patient to deliver treatment services. The patient should already be in the treatment area (e.g., on the treatment table or mat or in the gym) and prepared to begin treatment. The time counted is the time the patient is treated. For example, if gait training in a patient with a recent stroke requires both a therapist and an assistant, or even two therapists, to manage in the parallel bars, each 15 minutes the patient is being treated can count as only one unit of CPT® code 97116. The time the patient spends not being treated because of the need for toileting or resting should not be billed. In addition, the time spent waiting to use a piece of equipment or for other treatment to begin is not considered treatment time.

Regardless of the number of units billed, the daily maximum for services will not be exceeded.

WORK HARDENING AND WORK CONDITIONING

Work Hardening

Work hardening is an interdisciplinary, individualized, job specific program of activity with the goal of return to work. Work hardening programs use real or simulated work tasks and progressively graded conditioning exercises that are based on the individual's measured tolerances. Work hardening provides a transition between acute care and successful return to work and is designed to improve the biomechanical, neuromuscular, cardiovascular and psychosocial functioning of the worker.

Work hardening programs require prior approval by the worker's attending physician and prior authorization by the claim manager.

Only department approved work hardening providers will be paid for work hardening services.

More information about the department's work hardening program, including a list of approved work hardening providers, criteria for admission into a work hardening program and other work hardening program standards is available on the department's web site at http://www.LNI.wa.gov/ClaimsInsurance/Providers/ReturnToWork/WorkHard/default.asp This information is also available by calling the Provider Hotline at 1-800-848-0811 or the work hardening program reviewer at (360) 902-5622.

Work hardening CPT® codes 97545 and 97546 are not covered. Work hardening services are paid with local codes 1000M-1018M. Refer to the Local Codes section of the Professional Services Fee Schedule for code descriptions and maximum fees.

Work Conditioning

The department does not recognize work conditioning as a special program. Work conditioning is paid according to the rules for outpatient physical and occupational therapy (see WAC 296-23-220 and WAC 296-23-230).

OSTEOPATHIC MANIPULATIVE TREATMENT

Only osteopathic physicians may bill osteopathic manipulative treatment (OMT) using CPT® codes 98925 through 98929. CPT® code 97140, manual therapy, is not covered for osteopathic physicians.

For OMT services (CPT® codes 98925-98929) body regions are defined as: head, cervical, thoracic, lumbar, sacral, pelvic, rib cage, abdomen and viscera regions; lower and upper extremities.

These codes ascend in value to accommodate the additional body regions involved. Therefore, only one code is payable per treatment. For example, if three body regions were manipulated, one unit of CPT® code 98926 would be payable.

OMT includes pre- and post-service work (e.g., cursory history and palpatory examination). E/M office visit services are not to be routinely billed in conjunction with OMT. E/M office visit service (CPT® codes 99201-99215) may be billed in conjunction with OMT **only when all of the following conditions are met:**

- When the E/M service constitutes a significant separately identifiable service that exceeds the usual pre- and post-service work included with OMT, and
- There is documentation in the patient's record supporting the level of E/M billed, and
- The E/M service is billed using the -25 modifier.

E/M codes billed on the same day as OMT without the -25 modifier will not be paid.

The E/M service may be caused or prompted by the same diagnosis as the OMT service. A separate diagnosis is not required for payment of E/M in addition to OMT services on the same day.

The department or Self-Insurer may reduce payment or process recoupments when E/M services are not documented sufficiently to support the level of service billed. The CPT® book describes the key components that must be present for each level of service.

ELECTRICAL STIMULATORS

Electrical Stimulators Used in the Office Setting

Providers using stimulators in the office setting may bill professional services for application of stimulators with the CPT® physical medicine codes when such application is within the provider's scope of practice.

Devices and Supplies for Home Use or Surgical Implantation

See the Transcutaneous Electrical Nerve Stimulators (TENS) section for policies pertaining to TENS units and supplies. Coverage policies for other electrical stimulators and supplies are described below.

Electrical Stimulator Devices for Home Use or Surgical Implantation

HCPCS Code	Brief Description	Coverage Status
E0744	Neuromuscular stim for scoli	Not covered
E0745	Neuromuscular stim for shock	Covered for muscle denervation only. Prior authorization is required.
E0747	Elec Osteo stim not spine	Prior authorization is required.
E0748	Elec Osteogen stim spinal	Not covered
E0749	Elec Osteogen stim, implanted	Authorization subject to utilization review.
E0755	Electronic salivary reflex s	Not covered
E0760	Osteogen ultrasound, stimltor	Covered for appendicular skeleton only (not the spine). Prior authorization is required.

Electrical Stimulator Supplies for Home Use

HCPCS Code	Brief Description	Coverage Status
A4365	Adhesive remover wipes	Payable for home use only Bundled for physician office use
A4455	Adhesive remover per ounce	
A4556	Electrodes, pair	
A4557	Lead wires, pair	
A4558	Conductive paste or gel	
A5119	Skin barrier wipes box pr 50	
A6250	Skin seal protect moisturizr	
E0731	Conductive garment for TENS	Not covered
E0740	Incontinence treatment system	Not covered

TRANSCUTANEOUS ELECTRICAL NERVE STIMULATORS (TENS)

PRESCRIBING TENS

TENS units may be prescribed by licensed medical, osteopathic, naturopathic and podiatric physicians and dental surgeons. Providers, both in and out-of state, who prescribe or dispense TENS units for State Fund injured workers must use the department's contracted vendor, Performance Modalities, Inc. (PMI).

DISPENSING TENS

Providers may maintain an inventory of some or all of the TENS units maintained by PMI or may order a TENS unit from PMI by calling 1-800-999-TENS (1-800-999-8367).

Providers who maintain an inventory of TENS units must notify PMI when they have dispensed a unit and PMI will replenish the inventory.

Providers may prescribe and dispense the following TENS units:

MANUFACTURER	TENS UNIT
American Imex	Interspec-IF(1)
American Imex	MicroCare II
American Imex	Premier AP
Electromedical Products	Alpha-Stim 100
Empi	Dynex V
Empi	Eclipse +
Empi	Epix VT
Empi	Epix XL
Sparta	Spectrum Max-SD

(1) This unit is classified by the FDA as a true interferential current stimulator. Only the interferential units listed in the PMI contract with the department are eligible for rental and purchase on an at-home basis. See Provider Update 03-01, *Transcutaneous Electrical Nerve Stimulation (TENS) Program* and Provider Bulletin 01-11, *Transcutaneous Electrical Nerve Stimulation (TENS).* Interferential units must be obtained from PMI.

TENS Instruction

The department allows the initial TENS application and training by a physical therapist or other qualified provider only once per claim. This service must be billed with CPT® code 64550.

Trial Evaluation Period

A provider may dispense a TENS unit to an injured worker for a free trial evaluation period. Prior authorization is not required for the trial evaluation.

The trial evaluation period begins when the TENS unit is dispensed and may last up to 30 days. During the trial evaluation period, the provider and the injured worker assess whether the TENS treatment is working and if rental of the unit is medically necessary.

RENTAL AND PURCHASE OF TENS

TENS rental or purchase requires prior authorization by the insurer.

Rental Period

The department requires a 30-day trial evaluation period before TENS rental will be considered.

If the TENS unit is beneficial during the trial evaluation period, the prescribing provider may request authorization for a four-month rental period. If authorized, the four-month authorization is dated from the day the TENS unit was initially dispensed for the trial evaluation.

Providers may request authorization for rental of a TENS unit by contacting PMI at 1-800-999-TENS (1-800-999-8367).

Purchase

The department requires a four-month rental period before TENS purchase will be considered.

After a TENS unit has been rented for three months, PMI will send a TENS Purchase Recommendation form to the prescribing provider.

At the end of the four-month rental period, the prescribing provider must decide whether or not to pursue purchasing a TENS unit for the injured worker.

If the prescribing provider does not want to purchase the TENS unit, the prescribing provider must check box 12 on the TENS Purchase Recommendation form, sign and return it to PMI.

If the prescribing provider decides to pursue purchasing the TENS unit for the worker, the prescribing provider must submit the completed TENS Purchase Recommendation form to PMI. PMI will submit the TENS purchase request to the department for consideration and will notify the provider and the injured worker of the department's authorization decision.

Second Purchase Review

If the TENS unit purchase request is denied and the prescribing provider and injured worker disagree with the department's decision, the provider may submit a written request for a second purchase review.

The second purchase review must be submitted to PMI within 30 days of notice of TENS purchase denial and must include additional objective information supporting both the injured worker's functional improvement and the effectiveness of TENS therapy.

PMI will submit the second purchase request to the department for consideration and will notify the provider and the injured worker of the department's authorization decision.

TENS Supplies

The department will pay for medically necessary supplies and batteries for the life of the TENS unit if the department has authorized the injured worker's use of the TENS unit for an accepted condition. All supplies and batteries must be obtained from PMI.

TENS Unit Repair and Replacement

TENS units dispensed on or after January 1, 2003, have a five-year warranty. TENS units dispensed prior to that date may or may not still be under warranty. Regardless of warranty status, TENS unit repair is a covered service as long as the damage to the TENS unit has not been caused by injured worker abuse, neglect or misuse. The department and PMI, at their discretion, will decide when or if to repair a TENS unit or replace it with a TENS unit comparable to the original unit. In cases where damage to the TENS unit is due to injured worker abuse, neglect or misuse, TENS unit repair or replacement is the responsibility of the injured worker. Replacement of a lost or stolen TENS unit is also the responsibility of the injured worker.

TENS Billing Codes

The department's contracted vendor and providers treating Self-Insured workers must use the appropriate HCPCS codes to bill for TENS units and supplies.

Sales tax and delivery charges are not separately payable and must be included in the total charge for the TENS unit and supplies.

HCPCS Code	Brief Description	Coverage Status
A4595	TENS Supp 2 lead per month	For State Fund claims: Payable to the department's contracted TENS vendor. For Self-Insured claims: Payable to DME suppliers.
A4630	Repl batt TENS own by pt	
E0730	TENS, four lead	

CHIROPRACTIC SERVICES

Chiropractic physicians must use the codes listed in this section to bill for services. In addition, chiropractic physicians must use the appropriate CPT® codes for radiology, office visit and case management services and HCPCS codes for miscellaneous materials and supplies.

Evaluation and Management

Chiropractic physicians may bill the first four levels of new and established patient office visit codes (CPT® 99201-99204 and 99211-99214). The department uses the CPT® definitions for new and established patients. If a provider has treated a patient for any reason within the last three years, the person is considered an established patient. Refer to a CPT® book for complete code descriptions, definitions and guidelines.

The following payment policies apply when chiropractic physicians use E/M office visit codes:

- A new patient E/M office visit code is payable only once for the initial visit.
- An established patient E/M office visit code is not payable on the same day as a new patient E/M office visit code.
- Office visits in excess of 20 visits or 60 days require prior authorization.
- Modifier -22 is not payable with E/M codes for chiropractic services.
- Established patient E/M codes are not payable in addition to L&I chiropractic care visit codes for follow-up visits.
- Refer to the Chiropractic Care Visits section for policies about the use of E/M office visit codes with chiropractic care visit codes.

Chiropractic Care Visits

Chiropractic care visits are defined as office or other outpatient visits involving subjective and objective assessment of patient status, management and treatment. The levels of treatment are based on clinical complexity (similar to established patient evaluation and management services). Extremities are considered as one of the body regions and are not billed separately.

CPT® codes for chiropractic manipulative treatment (CPT® 98940-98943) are not covered. The department has developed the following clinical complexity based local codes for chiropractic care visits.

2050A	Level 1: Chiropractic Care Visit (straightforward complexity)	$ 36.33
2051A	Level 2: Chiropractic Care Visit (low complexity)	$ 46.53
2052A	Level 3: Chiropractic Care Visit (moderate complexity)	$ 56.68

The following payment policies apply to the use of chiropractic care visit codes:

- Only **one** chiropractic care visit code is payable per day.
- Office visits in excess of 20 visits or 60 days require prior authorization.
- Modifier -22 will be individually reviewed when billed with chiropractic care visit local codes (2050A-2052A). A report is required detailing the nature of the unusual service and the reason it was required. Payment will vary based on findings of the review. No payment will be made when this modifier is used for non-covered or bundled services (for example: application of hot or cold packs).
- See information below for the use of chiropractic codes with E/M office visit codes.

Use of Chiropractic Care Visit Codes with E/M Office Visit Codes

Chiropractic care visit codes (local codes 2050A-2052A) are payable in addition to E/M office visit codes (CPT® 99201-99204 and 99211-99214) **only when all of the following conditions are met:**

- The E/M service is for the initial visit for a new claim, and
- The E/M service constitutes a significant separately identifiable service that exceeds the usual pre- and post-service work included in the chiropractic care visit, and
- Modifier -25 is added to the new patient E/M code, and
- Supporting documentation describing the service(s) provided is in the patient's record.

When a patient requires reevaluation for an existing claim, either an established patient E/M code (CPT® codes 99211-99214) or a chiropractic care local code (2050A-2052A) is payable. Payment will not be made for both. Modifier -25 is not applicable in this situation.

Selecting the Level of Chiropractic Care Visit Code

The following table outlines the treatment requirements, presenting problems and face-to-face patient time involved in the three levels of chiropractic care visits.

Clinical decision making complexity is the primary component in selecting the level of chiropractic care visit. The department defines clinical decision making complexity according to the definitions for medical decision making complexity in the *Evaluation and Management Services Guidelines* section of the CPT® book.

	Selecting the Level of Chiropractic Care Visit		
	Primary Component	**Other Components**	
	Clinical decision making is typically	**Typical number of body regions(1) manipulated**	**Typical face-to-face time with patient and/or family**
Level 1 (2050A)	Straightforward	Up to 2	Up to 10-15 minutes
Level 2 (2051A)	Low complexity	Up to 3 or 4	Up to 15-20 minutes
Level 3 (2052A)	Moderate complexity	Up to 5 or more	Up to 25-30 minutes

(1) Body regions for chiropractic services are defined as:

- Cervical (includes atlanto-occipital joint)
- Thoracic (includes costovertebral and costotransverse joints)
- Lumbar
- Sacral
- Pelvic (includes sacro-iliac joint)
- Extraspinal: Any and all extraspinal manipulations are considered to be one region. Extraspinal manipulations include head (including temporomandibular joint, excluding atlanto-occipital), lower extremities, upper extremities and rib cage (excluding costotransverse and costovertebral joints).

Chiropractic Care Visit Examples

The following examples of chiropractic care visits are for illustrative purposes only. They are not intended to be clinically prescriptive.

EXAMPLES	
Level 1 **Chiropractic Care Visit** (straightforward complexity)	26-year-old male presents with mild low back pain of several days duration. Patient receives manipulation/adjustment of the lumbar region.
Level 2 **Chiropractic Care Visit** (low complexity)	55-year-old male presents with complaints of neck pain, midback and lower back pain. Patient receives 5 minutes of myofascial release prior to being adjusted. The cervical, thoracic and lumbar regions are adjusted.
Level 3 **Chiropractic Care Visit** (moderate complexity)	38-year-old female presents with headache, right anterior rib pain, low back pain with pain at the sacrococcygeal junction, as well as pain in the sacroiliac regions and right sided foot drop. Patient receives 10 minutes of moist heat application, 10 minutes of myofascial work, and manipulation/adjustment to the cervical and atlanto-occipital, thoracic, anterior rib area, lumbar, sacroiliac and sacrococcygeal regions.

Complementary and Preparatory Services

Chiropractic physicians are not separately paid for patient education or complementary and preparatory services. The department defines complementary and preparatory services as interventions that are used to prepare a body region for or facilitate a response to a chiropractic manipulation/adjustment. The application of heat or cold is considered a complementary and preparatory service.

For example: routine patient counseling regarding lifestyle, diet, self-care and activities of daily living, thermal modalities or some soft tissue work, exercise instruction involving a provision of a sheet of home exercises and a description in the course of a routine office visit.

Physical Medicine Treatment

CPT® physical medicine codes 97001-97799 are not payable to chiropractic physicians. Refer to Non-Board Certified/Qualified Physical Medicine Providers for more information.

Case Management

Refer to Case Management Services in the Evaluation and Management section for information on billing for case management services. These codes may be paid in addition to other services performed on the same day.

Consultations

Approved chiropractic consultants may bill the first four levels of CPT® office consultation codes (99241-99244). The department periodically publishes a policy on consultation referrals. This also includes a list of approved chiropractic consultants. To obtain the most recent bulletin, call the department's Provider Hotline at 1-800-848-0811 or refer to the Provider Bulletin website at http://www.LNI.wa.gov/ClaimsInsurance/Providers/ProviderBulletins/default.asp

Chiropractic Independent Medical Exams

Chiropractic physicians must be on the Approved Examiners List to perform independent medical exams (IMEs). To be considered for placement on the Approved Examiners List, a chiropractic physician must have all of the following:

- Two years experience as a chiropractic consultant on the department's approved consultant list, and

- Successfully completed the department's disability rating course for Washington State, and
- Attended the department's Chiropractic Consultant Seminar during the previous 24 months, and
- Submitted the written examination required for certification.

For more information, refer to the *Medical Examiners' Handbook* (publication F252-001-000). See http://www.LNI.wa.gov/ClaimsInsurance/Providers/IME/. Chiropractic physicians performing impairment ratings on their own patients or upon referral should refer to the *Medical Examiners' Handbook* and Impairment Rating by Attending Doctors/Consultants later in this section.

Supplies

See the Supplies, Materials, and Bundled Services section for information about billing for supplies.

Radiology Services

Chiropractic physicians must bill diagnostic x-ray services using CPT® radiology codes and the policies described in the Radiology Services section. If needed, x-rays immediately prior to and immediately following the initial chiropractic adjustment may be allowed without prior authorization. X-rays subsequent to the initial study require prior authorization.

Only chiropractic physicians who are on the department's list of approved radiological consultants may bill for x-ray consultation services. To qualify, a chiropractic physician must be a Diplomate of the American Chiropractic Board of Radiology and must be approved by the department.

PSYCHIATRIC SERVICES

The psychiatric services policies in this section apply only to workers covered by the State Fund and Self-Insured employer workers (see WAC 296-21-270 and Provider Bulletin 03-03). For information on psychiatric policies applicable to the Crime Victims Compensation Program, refer to the department's booklet *Mental Health Treatment Rules and Fees* (F800-090-000) and Chapter 296-31 WAC.

PSYCHIATRIC CONDITIONS

Treatment may be authorized for psychiatric conditions caused or aggravated by an industrial condition. Treatment may also be temporarily authorized for unrelated psychiatric conditions that are retarding recovery of an allowed industrial condition. **However, unrelated conditions are NOT the responsibility of the department.** The department will stop payment for temporary treatment of unrelated conditions when:

- The allowed industrial condition is resolved or
- The allowed industrial condition is no longer delayed from recovery by the unrelated psychiatric condition(s).

Psychiatric treatment must be provided in an "intensive" manner, which the department defines as at least 10-12 treatments in a 90-day authorization period. Prior authorization is required for **both** an initial psychiatric evaluation and for continued treatment.

PROVIDERS OF PSYCHIATRIC SERVICES

Authorized psychiatric services **must** be performed by either a psychiatrist (MD or DO) or a licensed psychologist (PhD), (see WAC 296-21-270). Licensed clinical psychologists and psychiatrists are paid at the same rate when performing the same service. Each provider must obtain his or her own L&I provider account number for billing and payment purposes.

The department does not cover psychiatric evaluation and treatment services provided by social workers, psychiatric nurse practitioners, and other master's level counselors, even when delivered under the direct supervision of a clinical psychologist or a psychiatrist. Staff supervised by a psychiatrist or licensed clinical psychologist may administer psychological testing; however, the psychiatrist or licensed clinical psychologist must interpret the testing and prepare the reports.

PSYCHIATRISTS AS ATTENDING PHYSICIANS

A psychiatrist can only be an injured worker's attending physician when the department has accepted a psychiatric condition and it is the **only** condition being treated. A psychiatrist may also rate psychiatric permanent partial disability. Psychologists cannot be the attending physician and may not certify time loss or rate Permanent Partial Disability under department rules (see WAC 296-20-210).

PSYCHIATRIC TREATMENT PLANS

The psychiatrist or psychologist must submit a goal-directed treatment plan and reports that contain a summary of subjective complaints, objective observations, assessment toward meeting measurable goals, an updated intensive goal-directed treatment plan and include the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders*, 4th edition (DSM-IV or current edition) axis format assessment.

Doctors treating psychiatric conditions allowed on a claim need to submit progress reports to the claim manager every sixty days (see WAC 296-21-270). If temporary treatment has been authorized for an unrelated psychiatric condition, progress reports need to be submitted to the claim manager every thirty days (see WAC 296-20-055).

NON-COVERED AND BUNDLED PSYCHIATRIC SERVICES

The following services are not covered:

CPT® Code	Abbreviated Description
90802, 90810-90815, 90823-90829 and 90857	Intacpsy dx interview; Intac psytx, off; Intac psytx, off, w/e&m; Intac psytx, hosp; Intac psytx, hosp, w/e&m; Intac psytx group
90845	Psychoanalysis
90846	Family psytx w/o patient
90849	Multiple family group psytx

The following services are bundled and are not payable separately:

CPT® Code	Abbreviated Description
90885	Psy evaluation of records
90887	Consultation with family
90889	Preparation of report

PSYCHIATRIC CONSULTATIONS AND EVALUATIONS

All referrals for psychiatric care require prior authorization (see WAC 296-21-270). This requirement includes referrals for psychiatric consultations and evaluations.

When an authorized referral is made to a psychiatrist, the psychiatrist may bill either the E/M consultation codes (CPT® codes 99241-99275) or the psychiatric diagnostic interview examination code (CPT® code 90801).

When an authorized referral is made to a clinical psychologist for an evaluation, the psychologist may bill only the psychiatric diagnostic interview exam code (CPT® code 90801).

Authorization for CPT® code 90801 is limited to one occurrence every six months, per patient, per provider.

Refer to WAC 296-20-045 and WAC 296-20-051 for more information on consultation requirements.

CASE MANAGEMENT SERVICES

Psychiatrists and clinical psychologists may only bill for case management services (CPT® codes 99361, 99362 and 99371-99373) when providing consultation or evaluation.

Refer to Case Management Services in the Evaluation and Management section for payment criteria and documentation requirements for case management services.

INDIVIDUAL INSIGHT ORIENTED PSYCHOTHERAPY

Individual insight oriented psychotherapy services are divided into services with an E/M component and services without an E/M component. Coverage of these services is different for psychiatrists and clinical psychologists.

Psychiatrists may bill individual insight oriented psychotherapy codes either with or without an E/M component (CPT® codes 90804-90809, 90816-90819 and 90821-90822). Psychotherapy with an E/M component may be billed when services such as medical diagnostic evaluation, drug management, writing physician orders and/or interpreting laboratory or other medical tests are conducted along with psychotherapy treatment.

Clinical psychologists may bill only the individual insight oriented psychotherapy codes without an E/M component (CPT® codes 90804, 90806, 90808, 90816, 90818 and 90821). They may not bill psychotherapy with an E/M component because medical diagnostic evaluation, drug management, writing physician orders and/or interpreting laboratory or other medical tests are outside the scope of clinical psychologist licensure.

Further explanation of this policy and CMS's response to public comments about it are published in *Federal Register* Volume 62 Number 211, issued on October 31, 1997.

Billing Tip

To report individual psychotherapy, use the time frames in the CPT® code descriptions for each unit of service. When billing these codes, do not bill more than one unit per day. When the time frame is exceeded for a specific code, bill the code with the next highest time frame.

USE OF CPT® EVALUATION AND MANAGEMENT CODES FOR PSYCHIATRIC OFFICE VISITS

Psychologists may not bill the E/M codes for office visits.

Psychiatrists may not bill the E/M codes for office visits on the same day psychotherapy is provided for the same patient. If it becomes medically necessary for the psychiatrist to provide an E/M service for a condition other than that for which psychotherapy has been authorized, the provider must submit documentation of the event and request a review before payment can be made.

PHARMACOLOGICAL EVALUATION AND MANAGEMENT

Pharmacological evaluation (CPT® code 90862) is payable only to psychiatrists. If a pharmacological evaluation is conducted on the same day as individual psychotherapy, the psychiatrist must bill the appropriate psychotherapy code with an E/M component. The psychiatrist must not bill the individual psychotherapy code and a separate E/M code in this case (CPT® codes 99201-99215). No payment will be made for psychotherapy and pharmacological management services performed on the same day, by the same physician, on the same patient.

HCPCS code M0064 is not payable in conjunction with the pharmacological evaluation code (CPT® code 90862) or with a CPT® E/M office visit or consultation code (CPT® codes 99201-99215, 99241-99275). The description for HCPCS code M0064 is "Brief office visit for the sole purpose of monitoring or changing drug prescriptions used in treatment of mental psychoneurotic and personality disorders." It will only be payable if these described conditions are accepted by the department as industrially related.

NEUROPSYCHOLOGICAL TESTING

The following three codes may be used if appropriate when performing neuropsychological evaluation. Reviewing records and/or writing and submitting a report is included in these codes and may not be billed separately.

CPT® Code	Abbreviated Description	Billing Restriction
90801	Psy dx interview	May be billed only once every six months.
96100	Psychological testing per hour	May be billed up to a four hour maximum. May be billed in addition to CPT® code 96117.
96117	Neuropsych test battery	May be billed per hour up to a twelve hour maximum.

GROUP PSYCHOTHERAPY SERVICES

Group psychotherapy treatment (CPT® code 90853) is authorized on an individual case-by-case basis only. If authorized, the worker may participate in group therapy as part of his or her individual treatment plan. The department does not pay a group rate to providers who conduct psychotherapy exclusively for groups of injured workers.

If group psychotherapy is authorized and performed on the same day as individual insight oriented psychotherapy (with or without an E/M component), both services may be billed, as long as they meet the CPT® definitions.

NARCOSYNTHESIS AND ELECTROCONVULSIVE THERAPY

Narcosynthesis (CPT® code 90865) and electroconvulsive therapy (CPT® codes 90870 and 90871) require prior authorization. Authorized services are payable only to psychiatrists because they require the administration of medication.

OTHER MEDICINE SERVICES

BIOFEEDBACK

Biofeedback treatment requires an attending doctor's order and prior authorization. Refer to WAC 296-20-03001 for information on what to include when requesting authorization. Rental of home biofeedback devices are time limited and require prior authorization. Refer to WAC 296-20-1102 for the department's policy on rental equipment.

The extent of biofeedback treatment is limited to those procedures allowed within the scope of practice of the licensed and approved biofeedback provider administering the service.

WAC 296-21-280 limits provision of biofeedback to those practitioners who are either certified by the Biofeedback Certification Institute of America (BCIA) or who meet the certification requirements. The WAC also sets forth authorization conditions, treatment limitations and reporting requirements for biofeedback services.

Anyone who is a qualified or certified biofeedback provider as defined in WAC 296-21-280, but is not licensed as a practitioner as defined in WAC 296-20-01002, may not receive direct payment for biofeedback services. These persons may perform biofeedback as paraprofessionals as defined in WAC 296-20-015 under the direct supervision of a qualified, licensed practitioner whose scope of practice includes biofeedback and who is BCIA certified or who meets the certification qualifications. The supervising licensed practitioner must bill the biofeedback services.

When biofeedback is performed in conjunction with individual psychotherapy, use either CPT® code 90875 or 90876 for psycho-physiological therapy; do not bill CPT® codes 90901 or 90911 with the individual psychotherapy codes.

The following table contains the biofeedback codes payable to approved providers:

Code	Abbreviated Description	Payable to:
CPT® 90875	Psychophysiological therapy 20-30 min	Department approved biofeedback providers who are: Clinical Psychologists or Psychiatrists (MD or DO).
CPT® 90876	Psychophysiological therapy 45-50 min	
CPT® 90901(1)	Biofeedback train, any meth	Any department approved biofeedback provider
CPT® 90911(1)	Biofeedback peri/uro/rectal	
HCPCS E0746	Electromyographbiofeedback	DME or pharmacy providers (for rental or purchase). Bundled for RBRVS providers for use in the office.

(1) CPT® codes 90901 and 90911 are not time limited and only one unit of service per day is payable, regardless of the length of the biofeedback session or number of modalities. Use appropriate evaluation and management codes for diagnostic evaluation services. CPT® code 90901 has replaced local codes 1042M and 1043M.

ELECTROMYOGRAPHY (EMG) SERVICES

Payment for needle electromyography (EMG) services (CPT® codes 95860-95870) is limited as follows:

CPT® Code	Abbreviated Description	Limitations
95860	Muscle test, one limb	• Extremity muscles innervated by 3 nerves or 4 spinal levels must be evaluated with a minimum of 5 muscles studied. • Not payable with CPT® code 95870
95861	Muscle test, two limbs	
95863	Muscle test, 3 limbs	
95864	Muscle test, 4 limbs	
95869	Muscle test, thor paraspinal	• May be billed alone (for thoracic spine studies only) • Limited to one unit per day • For this to pay with extremity codes, test must be for T3-T11 areas only; if only T1 or T2 are studied it is not payable separately.
95870	Muscle test, non-paraspinal	• Limited to one unit per extremity and one unit for cervical or lumbar paraspinal muscles regardless of the number of levels tested. • Not payable with extremity codes (5 units maximum payable)

ELECTROCARDIOGRAMS (EKG)

Separate payment is allowed for electrocardiograms (CPT® codes 93000, 93010, 93040 and 93042) when an interpretation and report is included. These services may be paid in conjunction with office services. EKG tracings without interpretation and report (CPT® codes 93005 and 93041) are not payable in addition to office services.

Transportation of portable EKG equipment to a facility or other patient location (HCPCS code R0076) is bundled into the EKG procedure and is not separately payable.

EXTRACORPOREAL SHOCKWAVE THERAPY (ESWT)

The department does not cover extracorporeal shockwave therapy because there is insufficient evidence of effectiveness of ESWT in the medical literature.

VENTILATOR MANAGEMENT SERVICES

No payment will be made for ventilator management services (CPT® codes 94656, 94657, 94660 and 94662) when an E/M service (CPT® codes 99201-99499) is reported on the same day by the same provider. Providers will be paid for either the appropriate ventilation management code or the E/M service, but not both. If a provider bills a ventilator management code on the same day as an E/M service, payment will be made for the E/M service and not for the ventilator management code.

MEDICATION ADMINISTRATION

Immunizations

Refer to WAC 296-20-03005 for authorization and requirements for work related exposure to an infectious disease. If authorized, immunization materials are payable. Immunization administration codes (CPT® codes 90471 and 90472) are payable in addition to the immunization materials code(s). Add-on CPT® code 90472 is limited to a maximum of one unit per day. An E/M code is not payable in addition to the immunization administration service, unless it is performed for a separately identifiable purpose and billed with a -25 modifier. Refer to Provider Bulletin 01-06 for the department's policy on post-exposure prophylaxis for bloodborne pathogens.

Immunotherapy

Professional services for the supervision and provision of antigens for allergen immunotherapy must be billed as component services. Complete service codes (CPT® codes 95120-95134) will not be paid. The provider must bill as appropriate, one of the injection codes (CPT® codes 95115 or 95117) and one of the antigen/antigen preparation codes (CPT® codes 95145-95149, 95165 or 95170).

Infusion Therapy Services and Supplies for RBRVS Providers

Prior authorization is required for any scheduled or ongoing infusion therapy services (including supplies) performed in the office, clinic or home, regardless of who performs the service. Refer to the Home Health Services section for further information on home infusion therapy.

Outpatient infusion therapy services are allowed without prior authorization when medically necessary to treat urgent or emergent care situations that arise in an office or clinic. In these situations, infusion therapy services are payable to physicians, ARNPs, and PAs (CPT® codes 90780 and 90781). HCPCS code Q0081 is only payable to hospitals. Intravenous or intra-arterial therapeutic or diagnostic injection codes (CPT® codes 90783 and 90784) will not be paid separately in conjunction with the IV infusion codes (CPT® codes 90780 and 90781).

Providers will be paid for E/M office visits (CPT® codes 99201-99215) in conjunction with infusion therapy only if the services provided meet the service code definitions.

Billing instructions for non-pharmacy providers are located in Injectable Medications later in this section. Drugs supplied by a pharmacy must be billed on pharmacy forms with national drug codes (NDCs or UPCs if no NDC is available).

Infusion therapy supplies and related durable medical equipment such as infusion pumps are not separately payable for RBRVS providers. Payment for these items is bundled into the fee for the professional service. If rental or purchase of an infusion pump is medically necessary to treat a patient in the home, refer to the Home Health Services section for further information.

The department does **not** cover implantable infusion pumps and supplies (HCPCS codes A4220, E0782, E0783, E0785 and E0786). The department also does **not** cover the implantation of epidural or intrathecal catheters, including their revision, repositioning, replacement, or removal (CPT® codes 62350-62368).

NOTE: When a spinal cord injury is an accepted condition, the department or Self-Insurer may authorize payment for anti-spasticity medications by any indicated route of administration (e.g., some benzodiazepines, Baclofen). Prior authorization is required.

Placement of non-implantable epidural or subarachnoid catheters for single or continuous injection of mediations are covered services with CPT® 62310-62319, 62281-62284 and 62290-62294.

Intrathecal and epidural infusions of any substance other than anesthetic or contrast material are not covered (see WAC 296-20-03002). Infusion of any opiates and their derivatives (natural, synthetic or semi-synthetic) are not covered unless they are part of providing anesthesia, short term post operative pain management (up to 48 hours post discharge), or unless medically necessary in emergency situations (see WAC 296-20-03014). No exceptions to this payment policy will be granted.

Therapeutic or Diagnostic Injections

Professional services associated with therapeutic or diagnostic injections (CPT® code 90782 or 90788), are payable along with the appropriate HCPCS "J" code for the drug, as long as no E/M office visit service (CPT® codes 99201-99215) is provided on the same day. If an E/M office visit service is provided on the same day as an injection, providers will be paid only the E/M service and the appropriate HCPCS "J" code for the drug. Providers must document the name, strength, dosage and quantity of the drugs administered in the medical record.

Intra-arterial and intravenous diagnostic and therapeutic injection services (CPT® codes 90783 and 90784) may be billed separately and are payable if they are not provided in conjunction with IV infusion therapy services (CPT® codes 90780 and 90781).

NOTE*:* Injections of narcotics or analgesics are not permitted or paid in the outpatient setting except on an emergency basis (see WAC 296-20-03014) or for pain management related to outpatient surgical procedures and dressing and cast changes for severe soft tissue injuries, burns or fractures.

Dry needling is considered a variant of trigger point injections with medications. Dry needling is a technique where needles inserted (no medications are injected) directly into trigger point locations as opposed to the distant points or meridians used in acupuncture. The department does not cover acupuncture services
(see WAC 296-20-03002). Dry needling of trigger points must be billed using trigger point injection CPT® codes 20552 or 20553. Dry needling follows the same rules as trigger point injections in WAC 296-20-03001(14).

Injectable Medications

Providers must use the "J" codes for injectable drugs that are administered during an E/M office visit or other procedure. The "J" codes are not intended for self-administered medications.

When billing for a non-specific injectable drug, the name, strength, dosage and quantity of drug administered or dispensed must be noted on the bill as well as documented in the medical record.

Providers must bill their acquisition cost for the drugs. Department fees for injectable medications are based on the AWP. Payment is made according to the published fee schedule amount, or the billed charge for the covered drug(s), whichever is less.

Hyaluronic Acid for Osteoarthritis of the Knee

Hyaluronic acid injections are indicated only for osteoarthritis of the knee. Other uses are considered experimental, and therefore will not be paid.(see WAC 296-20-03002(6)).

Hyaluronic acid injections must be billed with CPT® injection procedure code 20610 and the appropriate HCPCS code (J7320 for Synvisc injections or J7317 for Hyalgan or Supartz injections).

The correct side of body modifier (-RT or -LT) is required for authorization and billing. If bilateral procedures are required, both modifiers must be authorized and each must be billed as a separate line item.

See Provider Bulletin 98-10 for more information about the use of hyaluronic acid for osteoarthritis of the knee.

Non-Injectable Medications

Providers may administer oral or non-injectable medications during office procedures or dispense them for short-term use until the worker can have their prescription filled at a pharmacy. In these cases, providers must bill the distinct "J" code that describes the medication. If no distinct "J" code describes the medication, the most appropriate non-specific HCPCS code listed below must be used:

HCPCS Code	Brief Description
J3535	Metered dose inhaler drug
J7599	Immunosuppressive drug, noc
J7699	Inhalation solution for DME
J7799	Non-inhalation drug for DME
J8499	Oral prescrip drug non-chemo
J8999	Oral prescription drug chemo

The name, strength, dosage and quantity of drug administered or dispensed must be noted on the bill as well as documented in the medical record. No payment will be made for pharmaceutical samples.

OBESITY TREATMENT

While obesity does not meet the definition of an industrial injury or occupational disease, temporary treatment of obesity may be allowed in some cases. All obesity treatment services require prior authorization. The department pays for obesity treatment by reimbursing the worker using the following codes:

Code	Description	Fee Limits
0440A	Weight loss program, joining fee, worker reimbursement	$ 136.47
0441A	Weight loss program, weekly fee, worker reimbursement	$ 27.30

The attending doctor may request a consultation with a registered dietitian or nutritionist (RD) to determine if an obesity treatment program is appropriate for the injured worker. Only RDs will be reimbursed for nutrition counseling services. Providers practicing in another state who are similarly certified or licensed may apply to be considered for reimbursement. RDs that do not already have a provider number may call the Provider Hotline at 1-800-848-0811 for a provider application. The RD may bill for authorized services using CPT® code 97802 or 97803. Both CPT© 97802 and 97803 are billed in 15 minute units. CPT© 97802 can be billed only for the initial visit, up to a maximum of 4 units. CPT© 97803 is billed up to a maximum of 2 units per visit with a maximum of 3 follow-up visits.

Code	**Abbreviated Description**	**Fee Limits**
CPT® 97802	Medical nutrition, indiv, in	$ 24.30
CPT® 97803	Medical nutrition, indiv, subseq	$ 24.30

IMPAIRMENT RATING EXAM AND REPORT BY ATTENDING DOCTORS AND CONSULTANTS

These local codes are for use by attending doctors who are doctors of medicine, osteopathic medicine and surgery, chiropractic, podiatry and dentistry. In accordance with WAC 296-23-267, doctors of naturopathy and optometry may not bill these codes. For more information on impairment rating, refer to the *Medical Examiners Handbook*.

Consultants performing impairment ratings must be on the department's list of approved examiners.

Code	**Description**	**Maximum Fee**
1190M	Impairment rating exam and report by attending doctor, limited	$ 221.62
1191M	Impairment rating exam and report by attending doctor, standard	$ 322.37
1192M	Impairment rating exam and report by attending doctor, complex	$ 402.95
1193M	Impairment rating exam and report by consultant, limited	$ 221.62
1194M	Impairment rating exam and report by consultant, standard	$ 322.37
1195M	Impairment rating exam and report by consultant, complex	$ 402.95

PHYSICIAN ASSISTANTS

Physician assistants must be certified to qualify for payment. Physician assistants must have valid individual L&I provider account numbers to be paid for services.

Consultations, impairment ratings and administrative or reporting services related to workers' compensation benefit determinations are not payable to physician assistants. Physician assistant services are paid to the supervising physician or employer at a maximum of 90% of the allowed fee.

Further information about physician assistant services and payment can be found in Provider Bulletin 99-04 and WAC 296-20-12501 and WAC 296-20-01501.

NATUROPATHIC PHYSICIANS

Naturopathic physicians must use the E/M CPT® codes to bill for office visit services, CPT® codes 99361-99373 to bill for case management services and the appropriate HCPCS codes to bill for miscellaneous materials and supplies.

USE OF CPT® EVALUATION AND MANAGEMENT CODES FOR NATUROPATHIC OFFICE VISITS

Naturopathic physicians may bill the first four levels of CPT® new and established patient office visit codes (99201-99204 and 99211-99214). The department uses the CPT® definitions for new and established patients. If a provider has treated a patient for any reason within the last three years, the person is considered an established patient. Refer to a CPT® book for complete code descriptions, definitions and guidelines.

Refer to Case Management Services in the Evaluation and Management section for payment criteria and documentation requirements for case management services.

The department will not pay naturopathic physicians for services that are not specifically allowed. Refer to Chapter 296-23 WAC for additional information.

PATHOLOGY AND LABORATORY SERVICES

PANEL TESTS

Automated Multichannel Tests

When billing for panels containing automated multichannel tests, performing providers may bill either the panel code or individual test codes, but not both.

The following tests are automated multichannel tests or panels comprised solely of automated multichannel tests:

CPT®	Abbreviated Description
80048	Basic metabolic panel
80051	Electrolyte panel
80053	Comprehensive metabolic panel
80069	Renal function panel
80076	Hepatic function panel
82040	Assay of serum albumin
82247	Bilirubin, total
82248	Bilirubin, direct
82310	Assay of calcium
82374	Assay, blood carbon dioxide
82435	Assay of blood chloride
82465	Assay of serum cholesterol
82550	Creatine kinase (CK) (CPK)
82565	Assay of creatine

CPT®	Abbreviated Description
82947	Assay of glucose, qualitative
82977	Assay of GGT
83615	Lactate (LD) (LDH) enzyme
84075	Assay alkaline phosphatase
84100	Assay of phosphorus
84132	Assay of serum potassium
84155	Assay pf protein
84295	Assay of serum sodium
84450	Transferase (AST) (SGOT)
84460	Alanine amino (ALT) (SGPT)
84478	Assay of triglycerides
84520	Assay of urea nitrogen
84550	Assay of blood/uric acid

Payment Calculation for Automated Tests

The automated individual and panel tests above will be paid based on the total number of unduplicated automated multichannel tests performed per day per patient. Payment calculation is made according to the following steps:

- When a panel is performed, the CPT® codes for each test within the panel are determined;
- The CPT® codes for each test in the panel are compared to any individual tests billed separately for that day;
- Any duplicated tests are denied;
- Then the total number of remaining unduplicated automated tests is counted. See the following table to determine the payable fee based on the total number of unduplicated automated tests performed:

Number of Tests	Fee
1 test	Lower of the single test or $10.19
2 tests	$10.19
3 -12 tests	$12.50
13 -16 tests	$16.69

Number of Tests	Fee
17 – 18 Tests	$18.70
19 Tests	$21.63
20 Tests	$22.33
21 Tests	$23.03
22 –23 Tests	$23.73

Payment Calculation for Panels with Automated and Non-Automated Tests

When panels are comprised of both automated multichannel tests and individual non-automated tests, they will be priced based on:

- The automated multichannel test fee based on the number of tests, added to
- The sum of the fee(s) for the individual non-automated test(s).

For example, panel test 80061 is comprised of two automated multichannel tests and one non-automated test. As shown below, the fee for 80061 is **$26.21.**

CPT® 80061 Component Tests	Number of Automated Tests	Maximum Fee
Automated: CPT® 82465 CPT® 84478	2	Automated: $ 10.19
Non-Automated: CPT® 83718		Non-Automated: $ 16.02
MAXIMUM PAYMENT:		$ 26.21

Payment Calculation for Multiple Panels

When multiple panels are billed or when a panel and individual tests are billed for the same date of service for the same patient, payment will be limited to the total fee allowed for the unduplicated component tests.

Example:

The table below shows how the maximum payment would be calculated if panel codes 80050, 80061 and 80076 were billed with individual test codes 82977, 83615, 84439 and 85025.

Test	CPT® PANEL CODES			INDIVIDUAL TESTS	Test Count	Max Fee
	80050	80061	80076			
Automated Tests	82040 84075 82247 84132 82310 84155 82374 84295 82435 84450 82565 84460 82947 84520	82465 84478	82040(1) 82247(1) 82248 84075(1) 84155(1) 84450(1) 84460(1)	82977 83615	19 Unduplicated Automated Tests	$ 21.63
Non-Automated Tests	84443 85025 or 85027 and 85004 or 85027 and 85007 or 85027 and 85009	83718	None	84439 85025 or 85027 and 85004 or 85027 and 85007 or 85027 and 85009 (1)		$ 32.75 $ 15.20 $ 16.02 $ 17.11 $ 0.00
MAXIMUM PAYMENT:						$ 81.08

(1) Duplicated tests

REPEAT TESTS

Additional payment will be allowed for repeat test(s) performed for the same patient on the same day. However, a specimen(s) must be taken from separate encounters. Test(s) normally performed in a series (e.g., glucose tolerance tests or repeat testing of abnormal results do not qualify as separate encounters). The medical necessity for repeating the test must be documented in the patient's record.

Modifier –91 must be used to identify the repeated test(s). Payment for repeat panel tests or individual components tests will be made based on the methodology described above.

SPECIMEN COLLECTION AND HANDLING

Specimen collection charges are allowed for provider or practitioner, independent laboratory or outpatient hospital laboratory services as follows:

- The fee is payable only to the provider (practitioner or laboratory) who actually draws the specimen.
- Payment for the specimen may be made to nursing homes or skilled nursing facilities when an employee who is qualified to do specimen collection performs the draw.
- Payment for performing the test is separate from the specimen collection fee.
- Costs for media, labor and supplies (e.g., gloves, slides, antiseptics, etc.) are included in the specimen collection.
- A collection fee is not allowed when the cost of collecting the specimen(s) is minimal, such as a throat culture, Pap smear or a routine capillary puncture for clotting or bleeding time.
- No fee is payable for specimen collection performed by patients in their homes (such as stool sample collection).

Billing Tip

Use CPT® code 36415 or HCPCS code G0001 for venipuncture. Use HCPCS code P9612 or P9615 for catheterization for collection of specimen.

Complex vascular injection procedures, such as arterial punctures and venisections, are not subject to this policy and will be paid with the appropriate CPT® or HCPCS codes.

No payment for travel will be made to nursing home or skilled nursing facility staff who perform the specimen collection. Travel will be paid in addition to the specimen collection fee when **all** of the following conditions are met:

- It is medically necessary for a provider, practitioner or laboratory technician to draw a specimen from a nursing home, skilled nursing facility or homebound patient, and
- the provider, practitioner or lab technician personally draws the specimen, and
- the trip is solely for the purpose of collecting the specimen.

If the specimen draw is incidental to other services, no travel is payable.

Billing Tip

Use HCPCS code P9603 to bill for actual mileage (one unit equals one mile). HCPCS code P9604 is not covered.

Payment will not be made for handling and conveyance, e.g., shipping or messenger or courier service of specimen(s) (CPT® codes 99000 and 99001). This includes preparation and handling of specimen(s) for shipping to a reference laboratory. These services are considered to be integral to the testing process and are bundled into the total fee for the testing service.

STAT LAB FEES

Usual laboratory services are covered under the Professional Services Fee Schedule. In cases where laboratory tests are appropriately performed on a STAT basis, the provider may bill HCPCS code S3600 or S3601. Payment is limited to one STAT charge per episode (not once per test). Tests ordered STAT should be limited to only those that are needed to manage the patient in a true emergency situation. The laboratory report should contain the name of the provider who ordered the STAT test(s). The medical record must reflect the medical necessity and urgency of the service.

The STAT charge will only be paid with the tests listed below.

CPT® Code	Abbreviated Description
80048	Basic metabolic panel
80051	Electrolyte panel
80069	Renal function panel
80076	Hepatic function panel
80100	Drug screen
80101	Drug screen
80156	Assay of carbamazepine
80162	Assay of digoxin
80164	Assay, dipropylacetic acid
80170	Assay of gentamicin
80178	Assay of lithium
80184	Assay of phenobarbital
80185	Assay of phenytoin, total
80188	Assay of primidone
80192	Assay of procainamide
80194	Assay of quinidine
80196	Assay of salicylate
80197	Assay of tacrolimus
80198	Assay of theophylline
81000	Urinalysis, nonauto w/scope
81001	Urinalysis, auto w/scope
81002	Urinalysis nonauto w/o scope
81003	Urinalysis, auto, w/o scope
81005	Urinalysis
82003	Assay of acetaminophen
82009	Test for acetone/ketones
82040	Assay of serum albumin
82055	Assay of ethanol
82150	Assay of amylase
82247	Bilirubin, total
82248	Bilirubin, direct
82310	Assay of calcium
82330	Assay of calcium
82374	Assay, blood carbon dioxide
82435	Assay of blood chloride
82550	Assay of ck (cpk)
82565	Assay of creatinine
82803	Blood gases: pH, pO2 & pCO2
82945	Glucose other fluid
82947	Assay of glucose, quant

CPT® Code	Abbreviated Description
83874	Assay of myoglobin
83880	Natriuretic peptide
84100	Assay of phosphorus
84132	Assay of serum potassium
84155	Assay of protein
84157	Protein, total, other source
84295	Assay of serum sodium
84302	Assay of sweat sodium
84450	Transferase (AST) (SGOT)
84484	Assay of troponin, quant
84512	Assay of troponin, qual
84520	Assay of urea nitrogen
84550	Assay of blood/uric acid
84702	Chorionic gonadotropin test
85004	Automated diff wbc count
85007	Differential WBC count
85025	Automated hemogram
85027	Automated hemogram
85032	Manual cell count, each
85046	Reticucytes/hgb concentrate
85049	Automated platelet count
85378	Fibrin degradation
85380	Fibrin degradation
85384	Fibrinogen
85396	Coagulation/fibrinolysis assay
85610	Prothrombin time
85730	Thromboplastin time, partial
86308	Heterophile antibodies
86403	Particle agglutination test
86880	Coombs test
86900	Blood typing, ABO
86901	Blood typing, Rh (D)
86920	Compatibility test
86921	Compatibility test
86922	Compatibility test
86971	RBC pretreatment
87205	Smear, stain & interpret
87210	Smear, stain & interpret
87281	Pneumocystis carinii, ag, if
87327	Cryptococcus neoform ag, eia

CPT® Code	Abbreviated Description
83615	Lactate (LD) (LDH) enzyme
83663	Fluoro polarize, fetal lung

CPT® Code	Abbreviated Description
87400	Influenza a/b, ag, eia
89051	Body fluid cell count

HCPCS Code	Abbreviated Description
G0306	Complete CBC, auto w/diff
G0307	Complete CBC, auto

PHARMACY AND DURABLE MEDICAL EQUIPMENT SERVICES

PHARMACY FEE SCHEDULE

Payment for drugs and medications, including all oral non-legend drugs, will be based on the pricing methodology described below. Refer to WAC 296-20-01002 for definitions of AWP and BLP.

The department's outpatient formulary can be found in **Appendix G** at the end of this document.

Drug Type	Payment Method
Generic	The lesser of BLP or AWP less 10% + $ 4.50 Professional Fee
Brand with Generic Equivalent (Substitution Allowed)	The lesser of BLP or AWP less 10% + $ 3.00 Professional Fee
Brand with Generic Equivalent (Dispensed as Written)	AWP less 10% + $ 4.50 Professional Fee
Single or multi-source brand name drugs	AWP less 10% + $ 4.50 Professional Fee

Compounded prescriptions will be paid at the allowed cost of the ingredients plus a compounding time fee of $4.00 per 15 minutes and a $4.50 professional fee.

Orders for over-the-counter non-oral drugs or non-drug items must be written on standard prescription forms. These items are to be priced on a 40% margin.

Prescription drugs and oral or topical over-the-counter medications are nontaxable (RCW 82.08.0281).

EMERGENCY CONTRACEPTIVES AND PHARMACIST COUNSELING

The department covers Emergency Contraceptive Pills (ECPs) and associated pharmacist counseling services when **all** of the following conditions are met:

- A valid claim for rape in the workplace is established with the insurer, and
- The ECP and/or counseling service is sought by the injured worker, and
- The claim manager authorizes payment for the ECP and/or the counseling, and
- The pharmacist is approved by the Department of Health Board of Pharmacy to follow this particular protocol.

Once these conditions have been met, the dispensed medication must be billed with the appropriate NDC and the counseling service with HCPCS code S9445.

INFUSION THERAPY

Services

The department will only pay home health agencies and/or independent registered nurses for infusion therapy services (CPT® codes 90780 and 90781) and/or therapeutic, diagnostic, vascular injections (CPT® codes 90782-90788 and 36000-36640). These services require prior authorization.

Supplies

Only pharmacies and DME suppliers, including IV infusion companies, may be paid for infusion therapy supplies. Supplies (including infusion pumps) require prior authorization and must be billed with HCPCS codes. Refer to WAC 296-20-1102 for information on the rental or purchase of infusion pumps.

Drugs

Infusion therapy drugs, including injectable drugs, are payable only to pharmacies. Drugs must be authorized and billed with NDC codes or UPC codes if no NDC codes are available.

DURABLE MEDICAL EQUIPMENT (DME)

Pharmacies and DME providers may bill for supplies and equipment with appropriate HCPCS and local codes. Delivery charges, shipping and handling, tax and fitting fees are not payable separately. DME suppliers should include these charges in the total charge for the supply. For taxable items, an itemized invoice may be attached to the bill but is not required.

DME suppliers may bill for equipment and supplies required to provide authorized IV infusion therapy under their L&I DME provider account number. Refer to WAC 296-20-1102 for information on the rental or purchase of infusion pumps.

The department pays for TENS units, services and supplies under contract only. Refer to the TENS section for more information.

For further information on miscellaneous services and appliances, refer to WAC 296-23-165.

BUNDLED CODES

Covered HCPCS codes listed as **bundled** in the fee schedules are payable to pharmacy and DME providers because there is no office visit or procedure associated with these provider types into which supplies can be bundled.

HOME HEALTH SERVICES

Attendant service, home health and hospice providers should use the codes listed in this section to bill for services. All of these services require prior authorization. The insurer will pay only for proper and necessary care and supplies needed because of physical restrictions caused by the industrial injury or disease. The insurer will not pay for services that are not specifically authorized.

Chore services and other services required to meet the worker's environmental needs are not covered except for home hospice care.

ATTENDANT SERVICES

Attendant services are proper and necessary personal care services provided to maintain the injured worker in his or her residence. All attendant services must be provided through a home health or home care agency except for spouses who provided department approved attendant services to their spouse prior to October 1, 2001. Spouses who met department criteria prior to the end of year 2002 may continue to provide non-agency care to their spouse. To be covered by the department, attendant services must be requested by the attending physician and authorized by the department before care begins.

The department will determine the maximum hours of authorized attendant services based on an independent nursing assessment of the worker's care needs. Refer to WAC 296-23-246 and Provider Bulletin 01-08 for additional information.

Covered Services

The insurer will approve hours of care based on an independent nursing evaluation. Respite care must be approved in advance. The following are examples of covered home health care services:

- Administration of medications
- Assistance with basic range of motion exercises
- Bathing and personal hygiene
- Bowel and incontinent care
- Dressing
- Feeding assistance (not meal preparation)
- Mobility assistance including walking, toileting and other transfers
- Specialized skin care including caring for or changing dressings or ostomies
- Tube feeding
- Turning and positioning

Non-Covered Services

Chore services and other services required to meet the worker's environmental needs are not covered. The following services are considered to be chore services:

- Childcare
- Shopping and other errands for the injured worker
- Yard work
- Laundry and other housekeeping activities
- Meal planning and preparation
- Transportation of the injured worker
- Recreational activities
- Other everyday environmental needs unrelated to the medical care of the injured worker

Attendant Service Codes

Code	Description	Fee
8901H	Attendant services by department approved spouse provider, per hour	$ 11.27
G0156	Services of home health aide in home health setting, each 15 minutes	$ 5.73

Additional Home Health Codes

Code	Description	Fee
8907H	Home health agency visit (RN), per day	$ 131.66
8912H	Home health agency visit (RN), each additional visit, per day	$ 55.37
G0151	Services of physical therapist in home health setting, each 15 minutes (1 hour limit per day)	$ 32.91
G0152	Services of occupational therapist in home health setting, each 15 minutes (1 hour limit per day)	$ 34.11
G0153	Services of speech and language pathologist in home health setting, each 15 minutes (1 hour limit per day)	$ 34.11
S9124	Nursing care, in the home by licensed practical nurse, per hour	$ 36.41

Nursing Evaluations

Independent nursing evaluations, when requested by the department or Self-Insurer, may be billed under Nurse Case Manager or Home Health Agency Visit (RN) codes, using their respective codes.

HOSPICE SERVICES

In-home hospice services must be preauthorized and may include chore services. For hospice services performed in a facility, please refer to Nursing Home, Hospice and Residential Care in the Facility Section. The following code applies to in-home hospice care:

Code	Description	Fee
S9126	Hospice care, in the home, per diem	BR

HOME INFUSION THERAPY SERVICES

Prior authorization is required for all scheduled or ongoing infusion therapy services, supplies and drugs provided in the home, regardless of who provides the service. Payment for performing home infusion therapy and injections of medication is included with the allowed payment for home health agency nursing services and may not be billed separately.

Refer to WAC 296-20-1102 for information on the rental or purchase of infusion pumps, which must be billed with HCPCS codes.

Infusion therapy drugs, including injectable drugs, are payable only to pharmacies. Drugs must be authorized and billed with NDC codes or UPC codes if no NDC codes are available.

SUPPLIES, MATERIALS AND BUNDLED SERVICES

Services and supplies must be medically necessary and must be prescribed by an approved provider for the direct treatment of a covered condition.

CPT® code 99070, which represents miscellaneous supplies and materials provided by the physician, will not be paid. Providers must bill specific HCPCS or local codes for supplies and materials provided during an office visit or with other office services.

Under the fee schedules, some services and supply items are considered bundled into the cost of other services (associated office visits or procedures) and will not be paid separately. See WAC 296-20-01002 for the definition of a bundled code. Bundled codes are listed as bundled in the dollar value column in the Professional Services Fee schedule. Refer to **Appendices B and C** for lists of bundled services and supplies.

ACQUISITION COST POLICY

Supply codes that do not have a fee listed will be paid at their acquisition cost. The acquisition cost equals the wholesale cost plus shipping and handling and sales tax. These items must be billed together as one charge. For taxable items, an itemized listing of the cost plus sales tax may be attached to the bill but is not required.

Wholesale invoices for all supplies and materials must be retained in the provider's office files for a minimum of five years. A provider must submit a hard copy of the wholesale invoice to the department or Self-Insurer when an individual supply item costs $150.00 or more, or upon request. The insurer may delay payment of the provider's bill if the insurer has not received this information.

Supplies used in the course of an office visit are considered bundled and are not payable separately. Fitting fees are bundled into the office visit or into the cost of any DME and are not payable separately.

Sales tax and shipping and handing charges are not paid separately, and must be included in the total charge for the supply. An itemized statement showing net price plus tax may be attached to bills but is not required.

CASTING MATERIALS

Providers should bill for casting materials with HCPCS codes Q4001-Q4051. The department no longer accepts HCPCS codes A4580-A4590 or local codes 2978M-2987M. No payment will be made for the use of a cast room. Use of a cast room is considered part of a provider's practice expense.

MISCELLANEOUS SUPPLIES

The following supplies were formerly billed with local codes and must be billed with HCPCS Code E1399:

- Therapeutic exercise putty
- Rubber exercise tubing
- Anti-vibration gloves

CATHETERIZATION

Separate payment is allowed for placement of a temporary indwelling catheter (CPT® codes 51702 and 51703) when performed in a provider's office and used to treat a temporary obstruction. Payment for the service is not allowed when the procedure is performed on the

same day or during the postoperative period of a major surgical procedure that has a follow-up period.

For catheterization to obtain specimen(s) for lab tests, see the Pathology and Laboratory Services section.

SURGICAL TRAYS AND SUPPLIES USED IN THE PHYSICIAN'S OFFICE

The department follows CMS's policy of bundling HCPCS codes A4263, A4300 and A4550 for surgical trays and supplies used in a physician's office.

SURGICAL DRESSINGS DISPENSED FOR HOME USE

The cost for surgical dressings that are applied during a procedure, office visit or clinic visit is included in the practice expense component of the RVU (overhead) for that provider. No separate payment is allowed.

Primary and secondary surgical dressings dispensed for home use are payable at acquisition cost when **all** of the following conditions are met:

- They are dispensed to a patient for home care of a wound, and
- They are medically necessary, and
- The wound is due to an accepted work related condition.

Primary Surgical Dressings

Primary surgical dressings are therapeutic or protective coverings applied directly to wounds or lesions either on the skin or caused by an opening to the skin. Examples of primary surgical dressings include items such as Telfa, adhesive strips for wound closure and petroleum gauze.

Secondary Surgical Dressings

Secondary surgical dressings serve a therapeutic or protective function and secure primary dressings. Examples include items such as adhesive tape, roll gauze, binders and disposable compression material. They do not include items such as elastic stockings, support hose and pressure garments. These items must be billed with the appropriate HCPCS or local codes.

Providers must bill the appropriate HCPCS code for each dressing item, along with the local modifier –1S for each item. Surgical dressing supplies and codes billed without the local modifier –1S are considered bundled and will not be paid.

HOT AND COLD PACKS OR DEVICES

Application of hot or cold packs (CPT® code 97010) is bundled for all providers.

WAC 296-20-1102 prohibits payment for heat devices for home use including heating pads. These devices are either bundled or not covered (see **Appendices B, C and D**).

OTHER SERVICES

AUDIOLOGY AND HEARING AID SERVICES

Information about the department's hearing aid services and devices reimbursement policies and rates can be found in Provider Bulletin 01-09.The Bulletin is available online at http://www.LNI.wa.gov/ClaimsInsurance/Providers/ProviderBulletins/default.asp

Caution Against Misleading Advertisements

The department may deny applications of health care providers to participate as a provider of services to injured workers, or terminate or suspend providers' eligibility to participate if the provider uses, causes or promotes the use of advertising matter, promotional materials or other representation, however disseminated or published, that is false, misleading or deceptive with respect to the industrial insurance system or benefits for injured workers (see RCW 51.36.130).

Hearing Loss Claims

The attending physician must validate the existence of a job related hearing loss. The physician may test or refer the injured worker to an otolaryngologist (ear, nose and throat specialist) or certified audiologist for hearing tests to determine whether there is a work related hearing loss.

The department or Self-Insurer will furnish hearing aids only when prescribed by a physician (see WAC 296-20-1101). The doctor must examine the worker prior to the department's hearing aid authorization.

The attending physician must submit a packet to the department containing **all** of the following:

- Report of Accident form, and
- Hearing Loss Work History form, and
- Copy of the valid audiogram, and
- Medical report.

The department or Self-Insurer needs all of the above information to approve or deny a hearing loss claim.

Hearing Aid Billing Codes

All hearing aids and supplies must be billed using HCPCS codes. Local codes are no longer valid. The department will only purchase the hearing aids described in the codes shown in the fee schedule.

When billing for hearing aids, indicate the following on the billing form:

- The diagnosis, as appropriate, for each side of the body.
- The appropriate HCPCS code for monaural or binaural aids. Only one unit of service should be billed, whether one (monaural aid) or two hearing aids (binaural aids) are dispensed.

AFTER HOURS SERVICES

After hours services (CPT® codes 99050-99054) will only be considered for separate payment when the provider's office is not regularly open. Only one after hours service code will be reimbursed per patient per day. After hours service codes are not payable when billed by emergency room physicians, anesthesiologists/anesthetists, radiologists and laboratory clinical staff. The medical necessity and urgency of the service must be documented in the medical records and be available upon request.

INTERPRETER SERVICES

These local codes are for use by interpreters who provide language communication between injured workers and medical or vocational service providers. Refer to

Provider Bulletins 03-01 and 03-10 for complete payment and eligibility information.

Code	Description	Maximum Fee	Code Limits
9986M	Interpreter mileage, per mile.	State employees' mileage rate	Mileage billed beyond 50 miles per day per claim and total mileage beyond 75 miles per day, to include all claims, will be a basis for review.
9989M	Interpreter services provided directly between the health care or vocational provider and the claimant, per minute.	$ 1.00 per minute	Billed time greater than 8 hours per day will be a basis for review.
9990M	Time spent assisting claimant with completion of insurer form, per minute, outside of the time spent with the provider of health or vocational services.	$ 1.00 per minute	
9991M	Wait time for an appointment that does not begin at the scheduled time, per minute.	$ 0.50 per minute	Billed time greater than 60 minutes will be a basis for review.
9996M	Interpreter "no show" wait time when a worker does not attend an insurer-requested IME, per minute.	$ 0.50 per minute	Billed time greater than 60 minutes will be a basis for review.
9997M	Document translation at insurer request, per minute.	$ 1.00 per minute	

MEDICAL TESTIMONY AND DEPOSITIONS

The Office of the Attorney General or the Self-Insurer makes arrangements with expert witnesses to provide testimony or deposition. Bills for these services should be submitted directly to the Office of the Attorney General or Self-Insurer. Although the department does not use codes for medical testimony, Self-Insurers must allow providers to use CPT® code 99075 to bill for these services.

Fees are calculated on a portal-to-portal time basis (from the time you leave your office until you return), which does not include side trips.

The time calculation for testimony or deposition performed in the provider's office or via phone is based upon the actual time used for the testimony or deposition.

The Office of the Attorney General, not the department, determines testimony fee and payment policies.

Testimony fees (applied to doctors as defined in WAC 296-20-01002)

Description	Maximum Fee
Medical testimony approved in advance by Office of the Attorney General, first hour	$ 384.41
Each additional 30 minutes	$ 128.14
Deposition approved in advance by Office of Attorney General, first hour	$ 320.35
Each additional 30 minutes	$ 107.31

Testimony fees (applied to all other health care providers)

Description	Maximum Fee
Medical testimony approved in advance by Office of the Attorney General, first hour	$ 80.00
Each additional 30 minutes	$ 40.00
Deposition approved in advance by Office of Attorney General, first hour	$ 80.00
Each additional 30 minutes	$ 40.00

Cancellation policy for testimony or depositions

Cancellation Date	Cancellation Fee
3 working days or less than 3 working days notice before a hearing or deposition	Department will pay a cancellation fee for the amount of time you were scheduled to testify, at the allowable rate.
More than 3 working days notice before a hearing or deposition	Department will not pay a cancellation fee.

NURSE CASE MANAGEMENT

All nurse case management services require prior authorization. Refer to Provider Bulletin 98-01 for a complete description of the services, provider qualifications and billing instructions.

Nurse case managers must use the following local codes to bill for nurse case management services, including nursing assessments:

Code	Description	Maximum Fee
1220M	Phone calls, per 6 minute unit	$ 8.50
1221M	Visits, per 6 minute unit	$ 8.50
1222M	Case planning, per 6 minute unit	$ 8.50
1223M	Travel/Wait, per 6 minute unit	$ 4.18
1224M	Mileage, per mile	State rate
1225M	Expenses (parking, ferry, toll fees, lodging and airfare) at cost or state per diem rate (lodging)	

Nurse case management services are capped at 50 hours of service, including professional and travel/wait time. An additional 25 hours may be authorized after staffing with the insurer. Further extensions may be granted in exceptional cases, contingent upon review by the insurer.

REPORTS AND FORMS

Providers should use the following CPT® or local codes to bill for special reports or forms required by the department or Self-Insurer. The fees listed below include postage for sending documents to the department or Self-Insurer:

Code	Report/Form	Maximum Fee	Special notes
CPT® 99080	Special Report (Sixty Day Report)	$ 33.55	Sixty day reports are required per WAC 296-20-06101 and do not need to be requested by the insurer. Not payable for records required to support billing or for review of records included in other services. Limit of one per day.
CPT® 99080	Special Report (Requested by insurer or VRC)	$ 33.55	**Must be requested by insurer or vocational counselor.** Not payable for records or reports required to support billing or for review of records included in other services. Do not use this code for forms or reports with assigned codes. Limit of one per day.
1026M	Attending Physician Final Report (PFR)	$ 33.55	**Must be requested by insurer.** Payable only to attending doctor. Not paid in addition to office visit on same day. Form will be sent from insurer. Provider must retain copy of completed form. Limit of one per day.
1027M	Loss of Earning Power (LEP)	$ 9.44	**Must be requested by insurer.** Payable only to attending doctor. Limit of one per day.
1037M	Physical Capacity Evaluation (PCE) or Restrictions	$ 21.42	**Must be requested by State Fund employer.** Payable to attending doctor, the treating physician assistant or advanced registered nurse practitioner. Use for State Fund claims only. Bill to the department (see Provider Bulletin 96-10).
1039M	Time Loss Notification (TLN)	$ 9.44	**Must be requested by insurer.** Payable only to attending doctor. Limit of one per day.
1040M	Report of Industrial Injury or Occupational Disease/ Report of Accident (ROA) – for State Fund claims	$ 25.69	Payable only to attending doctor. Paid when initiated by the injured worker or attending doctor. Limit of one per claim.
1040M	Physician's Initial Report – for Self Insured claims	$ 25.69	Payable only to attending doctor. Paid when initiated by the injured worker or attending doctor. Limit of one per claim.
1041M	Application to Reopen Claim	$ 25.69	Payable only to attending doctor. May be initiated by the injured worker or insurer (see WAC 296-20-097). Limit of one per request.

Code	Report/Form	Maximum Fee	Special notes
1048M	Doctor's Estimate of Physical Capacities	$ 21.42	**Must be requested by insurer or vocational counselor**. Payable to attending doctor, independent medical examiners, consultants, the treating physician assistant or advanced registered nurse practitioner. Limit of one per day per claim.
1055M	Occupational Disease History Form	$ 161.86	**Must be requested by insurer.** Payable only to attending doctor. Includes review of claimant information and preparation of report on relationship of occupational history to present condition(s).
1056M	Supplemental Medical Report (SMR)	$ 15.88	**Must be requested by insurer.** Payable only to attending doctor. Limit of one per day.
1057M	Opioid Progress Report Supplement	$ 15.88	Payable only to attending physician. Paid when the worker is prescribed opioids for chronic, non-cancer pain. Must be submitted at least every 60 days (see WACs 296-20-03021, -03022 and Provider Bulletin 00-04). Limit of one per day.
1063M	Attending Doctor Review of Independent Medical Exam (IME)	$ 34.27	**Must be requested by insurer.** Payable only to attending doctor. Limit of one per request.
1064M	Initial report documenting need for opioid treatment	$ 33.55	Payable only to the attending physician. Paid when initiating opioid treatment for chronic, non-cancer pain. See WAC 296-20-03020 and Provider Bulletin 00-04 for what to include in the report.

More information on some of the reports and forms listed above is provided in WAC 296-20-06101. Many department forms are available online at http://www.LNI.wa.gov/FormPublications/ and all reports and forms may be requested from the Provider Hotline at 1-800-848-0811. When required, the department or Self-Insurer will send special reports and forms.

COPIES OF MEDICAL RECORDS

Providers may bill for copies of medical records requested by the department, Self-Insurer or Self-Insurer representative using HCPCS code S9982. Payment for S9982 includes all costs, including postage. S9982 is not payable for services required to support billing or to commercial copy centers or printers who reproduce records for providers.

Only providers who have provided health care or vocational services to the injured worker may bill HCPCS code S9982. The insurer will pay for requested copies of medical records, regardless of whether the provider is currently treating the injured worker or has treated the worker at some time in the past, including prior to the injury. If the insurer requests records from a health care provider, the insurer will pay for the requested services. Payment will be made per copied page.

PROVIDER MILEAGE

Providers may bill for mileage when a round trip exceeds 14 miles.

Code	Description	Maximum Fee
1046M	Mileage, per mile, allowed when round trip exceeds 14 miles	$ 4.29

REVIEW OF JOB OFFERS AND JOB ANALYSES

A **job offer** is based on an employer's desire to offer a specific job to a worker. The job offer may be based on a job description or a job analysis. For more information about job offers, see RCW 51.32.09(4).

A **job description** is an employer's brief evaluation of a specific job or type of job that the employer intends to offer a worker.

A **job analysis (JA)** is a detailed evaluation of a specific job or type of job. A JA is used to help determine the types of jobs a worker could reasonably perform considering the worker's skills, work experience, non-work related skills and physical limitations or to determine the injured worker's ability to perform a specific job. The job evaluated in the JA may or may not be offered to the worker and it may or may not be linked to a specific employer.

Attending doctors, independent medical examiners (IME) and consultants will be paid for review of job descriptions or JA's. A job description/JA review may be performed at the request of the State Fund employer, the insurer, vocational rehabilitation counselor (VRC) or third party administrator (TPA) acting for the insurer or the employer. Reviews requested by other persons (e.g., attorneys or injured workers) will not be paid. This service does not require prior authorization if a vocational referral has been made. However, it does require authorization in any other circumstance. This service is payable in addition to other services performed on the same day.

A **provisional JA** is a detailed evaluation of a specific job or type of job requested when a claim has not been accepted. This service requires prior authorization and will not be authorized during an open vocational referral. A provisional JA must be conducted in a manner consistent with the requirements in WAC 296-19A-170. The provider assigned to or directly receiving the authorization from the referral source is responsible for all work performed by any individual on the job analysis.

Code	Report/Form	Maximum Fee	Special notes
1038M	Review of Job Descriptions or JA	$33.55	**Must be requested by insurer, State Fund employer or vocational counselor.** Payable to attending doctor, IME or consultant. Limit of one per day.
1028M	Review of Job Descriptions or JA, each additional review	$ 16.78	**Must be requested by insurer, State Fund employer or vocational counselor.** Payable to attending doctor, IME or consultant. Bill to the department (see Provider Bulletin 96-10).

VEHICLE, HOME AND JOB MODIFICATIONS

Vehicle, home and job modification services require prior authorization. Refer to

Provider Bulletin 96-11 for home modification information and Provider Bulletin 99-11 for job modification and pre-job accommodation information.

Code	Description	Maximum Fee
8914H	Home modification, construction and design	Maximum payable for all work is the current Washington state average annual wage.
8915H	Vehicle modification	Maximum payable for all work is ½ the current Washington state average wage. In the sole discretion of the Supervisor of Industrial Insurance after his or her review, the amount paid may be increased by no more than four thousand dollars by written order of the Supervisor of Industrial Insurance (RCW 51.36.020(8b).
8916H	Home modification evaluation and consultation	BR
8917H	Home/vehicle modification mileage, lodging, airfare, car rental	State rates
8918H	Vehicle modification initial evaluation or consultation	BR
8920H	Vehicle modification follow up consultation	BR
0380R	Job modification (equipment, etc.)	Maximum allowable for 0380R is $5,000 per job or job site.
0385R	Pre-job accommodation (equipment, etc.)	Maximum allowable for 0385R is $5,000 per claim. Combined costs of 0380R and 0385R for the same return to work goal cannot exceed $5,000.
0389R	Pre-job or job modification consultation (non-VRC), per 6 minutes	$ 9.41
0391R	Travel/wait time (non-VRC), per 6 minutes	$ 4.26
0392R	Mileage (non-VRC), per mile	State rates
0393R	Ferry Charges (non-VRC)	State rates

VOCATIONAL SERVICES

Vocational Rehabilitation providers must use the codes listed in this section to bill for services. For more detailed information on billing, consult the Miscellaneous Services Billing Instructions Section and Provider Bulletin 01-03.

All vocational rehabilitation services require prior authorization. Vocational rehabilitation services are authorized by referral type. The department uses six referral types: early intervention, assessment, plan development, plan implementation, forensic and stand alone job analysis. Each referral is a separate authorization for services.

The department will pay interns at 85% of the VRC professional rate and forensic evaluators at 120% of the VRC professional rate.

Early Intervention

Code	Description	Maximum Fee
0800V	Early Intervention Services (VRC), per 6 minutes	$ 7.74
0801V	Early Intervention Services (Intern), per 6 minutes	$ 6.58
0802V	Early Intervention Services Extension (VRC), per 6 minutes	$ 7.74
0803V	Early Intervention Services Extension (Intern), per 6 minutes	$ 6.58

Assessment

Code	Description	Maximum Fee
0810V	Assessment Services (VRC), per 6 minutes	$ 7.74
0811V	Assessment Services (Intern), per 6 minutes	$ 6.58

Vocational Evaluation

Code	Description	Maximum Fee
0821V	Work Evaluation (VRC), per 6 minutes	$ 7.74
0823V	Pre-Job or Job Modification Consultation (VRC), per 6 minutes	$ 7.74
0824V	Pre-job or Job Modification Consultation (Intern), per 6 minutes	$ 6.58

Plan Development

Code	Description	Maximum Fee
0830V	Plan Development Services (VRC), per 6 minutes	$ 7.74
0831V	Plan Development Services (Intern), per 6 minutes	$ 6.58

Plan Implementation

Code	Description	Maximum Fee
0840V	Plan Implementation Services (VRC), per 6 minutes	$ 7.74
0841V	Plan Implementation Services (Intern), per 6 minutes	$ 6.58

Forensic and Testimony

Code	Description	Maximum Fee
0881V	Forensic Services (Forensic VRC), per 6 minutes	$ 9.29
0882V	Testimony on VRC's Own Work (VRC), per 6 minutes	$ 7.74
0883V	Testimony on Intern's Own Work (Intern), per 6 minutes	$ 6.58
0884V	AGO Witness Testimony (VRC), per 6 minutes	$ 7.74

Travel, Wait Time, and Mileage

Code	Description	Maximum Fee
0891V	Travel/Wait Time (VRC or Forensic VRC), per 6 minutes	$ 3.88
0892V	Travel/Wait Time (Intern), per 6 minutes	$ 3.88
0893V	Professional Mileage (VRC), per mile	State rate
0894V	Professional Mileage (Intern), per mile	State rate
0895V	Air Travel (VRC, Intern, or Forensic VRC)	BR

Stand Alone Job Analysis

The codes in this table are used for stand alone and provisional job analyses.

Code	Description	Maximum Fee
0808V	Stand Alone Job Analysis (VRC), per 6 minutes	$ 7.74
0809V	Stand Alone Job Analysis (Intern), per 6 minutes	$ 6.58
0378R	Stand Alone Job Analysis (non-VRC), per 6 minutes	$ 7.74

See Provider Bulletin 03-08 for additional information.

Vocational Evaluation and Related Codes for Non-Vocational Providers

Certain non-vocational providers may deliver the above services with the following codes:

Code	Description	Maximum Fee
0389R	Pre-job or Job Modification Consultation	$ 9.41
0390R	Work Evaluation	$ 7.74
0391R	Travel/Wait (non-VRC)	$ 4.26
0392R	Mileage (non-VRC)	State rates
0393R	Ferry Charges (non-VRC)(1)	State rates

(1) Requires documentation with a receipt in the case file.

A provider can use the R codes if he or she is a:

- Non-vocational provider such as an occupational or physical therapist, or
- Vocational provider delivering services for a referral assigned to a different payee provider. As a reminder to vocational providers who deliver ancillary services on vocational referrals assigned to other providers, if the provider resides in a different firm (that is, has a different payee provider number than you), you cannot bill as a vocational provider (a provider type 68). You must either use another provider number that is authorized to bill the ancillary services codes (type 34, 52 or 55) or obtain a miscellaneous services provider number (type 97) and bill the appropriate codes for those services.

NOTE*:* These providers use the miscellaneous services billing form, but must include certain additional pieces of information on bills to associate the costs of ancillary services to the vocational referral and to be paid directly for services:

- The vocational referral ID that can be obtained from the assigned vocational provider, and
- The service provider ID for the assigned vocational provider in the “Name of physician or other referring source” box at the top of the form, and
- Non-vocational providers own provider numbers at the bottom of the form

For more information, consult Provider Bulletin 01-03 and *Miscellaneous Services Billing Instructions* (F248-095-000).

Fee Caps

Vocational services are subject to fee caps. These fee caps are hard caps, with no exceptions. The following fee caps are by referral. All services provided for the referral are included in the cap.

In the case of early intervention services, a provider may request an extension of the fee cap in cases of **medically approved** graduated return to work (GRTW) or work hardening (WH) opportunities. The extension is for **one time only per claim** and does not create a new referral.

The extension is limited to a maximum of 20 hours of service over a maximum of 12 weeks. Providers should submit bills for these services in the same format as other vocational bills.

The claim manager must authorize the extension. No other early intervention professional services (i.e., services billed using 0800V and 0801V) may be provided once the extension has been approved. You may continue to bill for travel/wait, mileage and ferry charges as normal. Use codes 0802V and 0803V to bill for GRTW and WH services provided during the extension.

Description	Maximum Fee
Early Intervention Referral Cap	$ 1,587.00
Extension of Early Intervention Referral Cap	$ 1,548.00
Assessment Referral Cap	$ 2,647.00
Plan Development Referral Cap	$ 5,302.00
Plan Implementation Referral Cap	$ 5,008.00

The fee cap for work evaluation services applies to multiple referral types.

Description	Maximum Fee
Work Evaluation Services Cap	$ 1,161.00

For example, if $661 of work evaluation services is paid as part of an ability to work assessment (AWA) referral, only $500 is available for payment under another referral type.

Facility Services

This section contains payment policies and information for facility services.

All providers must follow the administrative rules, medical coverage decisions and payment policies contained within the *Medical Aid Rules and Fee Schedules*, Provider Bulletins and Provider Updates.

If there are any services, procedures or text contained in the CPT® and HCPCS coding books that are in conflict with the *Medical Aid Rules and Fee Schedules*, the department's rules and policies take precedence (see WAC 296-20-010).

All policies in this document apply to claimants receiving benefits from the State Fund, the Crime Victims Compensation Program and Self-Insurers unless otherwise noted.

Questions may be directed to the Provider Hotline at 1-800-848-0811 or to the Crime Victims Compensation Program at 1-800-762-3716.

FACILITY SERVICES TABLE OF CONTENTS

HOSPITAL PAYMENT POLICIES

HOSPITAL PAYMENT POLICIES OVERVIEW

Hospital payment policies established by the department are reflected in Chapters 296-20, 296-21, 296-23 and 296-23A WAC**,** Provider Bulletins 02-05 and 01-13, and the Hospital Billing Instructions.

L&I or Self-Insurers will pay for the costs of proper and necessary hospital services associated with an accepted industrial injury. No co-payments or deductibles are required or allowed from injured workers.

HOSPITAL BILLING REQUIREMENTS

All charges for hospital inpatient and outpatient services provided to injured workers must be submitted on the UB-92 billing form following the **UB-92 National Uniform Data Element Specifications.**

Hospitals are responsible for establishing criteria to define inpatient and outpatient services. All inpatient bills will be evaluated according to the department's Utilization Review Program. Inpatient bills submitted without a treatment authorization number may be selected for retrospective review.

For a current copy of the Hospital Billing Instructions, contact the Provider Hotline at 1-800-848-0811.

HOSPITAL INPATIENT PAYMENT INFORMATION

State Fund Payment Methods

Services for hospital inpatient care provided to injured workers covered by the State Fund are paid using three payment methods:

1. An All Patient Diagnosis Related Group (AP-DRG) system. See WAC 296-23A-0470 for exclusions and exceptions. The department currently uses AP-DRG Grouper version 14.1.
2. A statewide Per Diem rate for those AP-DRGs that have low volume or for inpatient services provided in Washington rural hospitals.
3. A Percent of Allowed Charges (POAC) for hospitals excluded from the AP-DRG system.

The following table provides a summary of how the above methods are applied.

Hospital Type or Location	Payment Method for Hospital Inpatient Services
Hospitals not in Washington	Paid by an Out-of-State POAC factor. Effective **July 1, 2004** the rate is **53.8%.**
Washington excluded Hospitals: • Children's Hospitals • Health Maintenance Organizations (HMOs) • Military Hospitals • Veterans Administration • State Psychiatric Facilities	Paid 100% of allowed charges.
• Washington Rural Hospitals [Department of Health (DOH) Peer Group 1]	Paid using Washington statewide per diem rates for designated AP-DRG categories: • Chemical dependency • Psychiatric • Rehabilitation • Medical • Surgical
All other Washington Hospitals	Paid on a per case basis for admissions falling within designated AP-DRGs.(1) For low volume AP-DRGs, Washington hospitals are paid using the statewide per diem rates for designated AP-DRG categories: • Chemical dependency • Psychiatric • Rehabilitation • Medical • Surgical

(1) See http://www.LNI.wa.gov/claimsinsurance/providerpay/feeschedules/default.asp for the current AP-DRG Assignment List.

Hospital Inpatient AP-DRG Base Rate

Effective **July 1, 2004** the AP-DRG Base Rate is **$ 7,539.66.**

Hospital Inpatient AP-DRG Per Diem Rates

Effective **July 1, 2004** the AP-DRG Per Diem Rates are as follows:

PAYMENT CATEGORY	RATE(1)	DEFINITION
Psychiatric AP-DRG Per Diem	**$ 912.61** Multiplied by the number of days allowed by the department. Payment will not exceed allowed billed charges.	AP-DRGs 424-432
Chemical Dependency AP-DRG Per Diem	**$ 696.50** Multiplied by the number of days allowed by the department. Payment will not exceed allowed billed charges.	AP-DRGs 743-751
Rehabilitation AP-DRG Per Diem	**$ 1,335.68** Multiplied by the number of days allowed by the department. Payment will not exceed allowed billed charges.	AP-DRG 462
Medical AP-DRG Per Diem	**$ 1,523.92** Multiplied by the number of days allowed by the department. Payment will not exceed allowed billed charges.	AP-DRGs identified as medical
Surgical AP-DRG Per Diem	**$ 2304.70** Multiplied by the number of days allowed by the department. Payment will not exceed allowed billed charges.	AP-DRGs identified as surgical

(1) For information on how specific rates are determined see Chapter 296-23A WAC in the *Medical Aid Rules and Fee Schedules.*

The AP-DRG Assignment List with AP-DRG codes and descriptions and length of stay is in the fee schedules section and is available online at http://www.LNI.wa.gov/claimsinsurance/providerpay/feeschedules/default.asp .

Additional Inpatient Hospital Rates

PAYMENT CATEGORY	RATE	DEFINITION
Transfer-out Cases	Unless the transferring hospital's charges qualify for low outlier status, the stay at this hospital is compared to the AP-DRGs average length of stay. If the patient's stay is less than the average length of stay, a per-day rate is established by dividing the AP-DRG payment amount by the average length of stay for the AP-DRG. Payment for the first day of service is two times the per-day rate. For subsequent allowed days, the basic per-day rate will be paid. If the patient's stay is equal to or greater than the average length of stay, the AP-DRG payment amount will be paid.	A transfer is defined as an admission to another acute care hospital within 7 days of a previous discharge.
Low Outlier Cases (costs are less than the threshold)	Hospital Specific POAC Factor multiplied by allowed billed charges.	Cases where the cost (1) of the stay is less than ten percent (10%) of the statewide AP-DRG rate or **$ 527.16**, whichever is greater.
High Outlier Cases (costs are greater than the threshold)	AP-DRG payment rate plus 100% of costs in excess of the threshold.	Cases where the cost (1) of the stay exceeds **$12,651.77** or two standard deviations above the statewide AP-DRG rate, whichever is greater.

(1) Costs are determined by multiplying the allowed billed charges by the hospital specific POAC factor.

Self-Insured Claims

Services for hospital inpatient care provided to injured workers covered by self-insured employers are paid using a hospital-specific POAC factor (see WAC 296-23A-0210).

Crime Victims Claims

Services for hospital inpatient care provided to crime victims covered by the Crime Victims Compensation Program are paid using Medicaid POAC factors (see WAC 296-30-090).

HOSPITAL OUTPATIENT PAYMENT INFORMATION

Services for hospital outpatient care provided to injured workers covered by the State Fund are paid using three payment methods:

1. Ambulatory Payment Classification (APC) system. See Chapter 296-23A WAC (Section 4) and Provider Bulletins 01-13 and 02-05 for a description of the department's APC system.
2. An amount established through the department's Professional Services Fee Schedule for items not covered by the APC system.
3. POAC for hospital outpatient services not paid by either the APC system or with an amount from the Professional Services Fee Schedule.

The following table provides a summary of how the above methods are applied.

Hospital Type or Location	Payment Method for Hospital Outpatient Services
Hospitals not in Washington State	Paid by an Out-of-State POAC factor. Effective **July 1, 2004** the rate is **53.8%.**
Washington Excluded Hospitals: • Children's Hospitals • Military Hospitals • Veterans Administration • State Psychiatric Facilities	Paid 100% of allowed charges
• Rehabilitation Hospitals • Cancer Hospitals • Rural Hospitals (DOH Peer Group 1) • Critical Access Hospitals • Private Psychiatric Facilities	Paid a facility-specific POAC
All other Washington Hospitals	Paid on a per APC (1) basis for services falling within designated APCs. For non-APC paid services, Washington hospitals are paid using an appropriate Professional Services Fee Schedule amount, or a facility-specific POAC(1).

(1) Hospitals will be sent their individual POAC and APC rate each year.

Hospital Outpatient Payment Process

Question	Answer	Payment Method
1. Does L&I cover the service?	No	Do Not Pay
	Yes	Go to question 2
2. Does the service coding pass the Outpatient Code Editor (OCE) edits?	No	Do Not Pay
	Yes	Go to question 3
3. Is the procedure on the inpatient-only list?	No	Go to question 4
	Yes	Pay POAC(1)
4. Is the service packaged?	No	Go to question 5
	Yes	Do Not Pay, but total the Costs for possible outlier(2) consideration. Go to question 7.
5. Is there a valid APC?	No	Go to question 6
	Yes	Pay the APC amount and total payments for outlier(2) consideration. Go to question 7.
6. Is the service listed in a Fee Schedule?	No	Pay POAC
	Yes	Pay the Facility Amount for the service
7. Does the service qualify for outlier?(1)	No	No outlier payment
	Yes	Pay outlier amount (3)

(1) If only 1 line item on the bill is IP, the entire bill will be paid POAC.
(2) Only services packaged or paid by APC are used to determine outlier payments.
(3) Outlier amount is in addition to regular APC payments.

Self-Insured Claims

Services for hospital outpatient care provided to injured workers covered by Self-Insured employers are paid using facility-specific POAC factors or the appropriate Professional Services Fee Schedule amounts (see WAC 296-23A-0221).

Crime Victims Claims

Services for hospital outpatient care provided to crime victims covered by the Crime Victims Compensation Program are paid using either Medicaid POAC factors or the Professional Services Fee Schedule amounts (see WAC 296-30-090).

AMBULATORY SURGERY CENTER (ASC) PAYMENT POLICIES

ASC GENERAL INFORMATION

Information about the department's requirements for ASCs can be found in Chapter 296-23B WAC, available online at http://www.LNI.wa.gov/ClaimsInsurance/Rules/default.asp and in Provider Bulletin 01-12, available online at http://www.LNI.wa.gov/ClaimsInsurance/Providers/ProviderBulletins/default.asp.

ASC SERVICES INCLUDED IN THE FACILITY PAYMENT

Facility payments for ASCs include the following services which are not paid separately:

- Nursing, technician and related services
- Use by the recipient of the facility including the operating room and the recovery room
- Drugs, biologics, surgical dressings, supplies, splints, casts and appliances and equipment directly related to the provision of surgical procedures
- Diagnostic or therapeutic services or items directly related to the provision of a surgical procedure
- Administration, record keeping and housekeeping items and services
- Intraocular lenses
- Materials for anesthesia
- Blood, blood plasma and platelets

ASC SERVICES NOT INCLUDED IN THE FACILITY PAYMENT

Facility payments for ASCs do not include the following services which are paid separately:

- Professional services including physicians
- Laboratory services
- X-Ray or diagnostic procedures other than those directly related to the performance of the surgical procedure
- Prosthetics and implants except intraocular lenses
- Ambulance services
- Leg, arm, back and neck braces
- Artificial limbs
- DME for use in the patient's home

ASC PROCEDURES COVERED FOR PAYMENT

The department will use the CMS list of procedures covered in an ASC plus additional procedures determined by the department. All procedures covered in an ASC are listed in the Provider Billing and Fees, Fee Schedules section available online at http://www.LNI.wa.gov/ClaimsInsurance/ProviderPay/FeeSchedules/default.asp.

The department expanded the list that CMS established for allowed procedures in an ASC. There are three areas where the list has been expanded:

1. L&I will cover surgical procedures that other Washington State agencies cover in ASCs and that meet L&I's coverage policies.
2. L&I will cover surgical procedures that CMS covers in its hospital outpatient prospective payment system (OPPS) that are not on the CMS ASC list and that meet L&I's coverage policies.
3. L&I will cover some procedures in an ASC that CMS covers only in an inpatient setting if both of the following criteria are met:
    a. The surgeon deems that it is safe and appropriate to perform such a procedure in an outpatient setting, and
    b. The procedure meets the department's utilization review requirements.

ASC PROCEDURES NOT COVERED FOR PAYMENT

Procedures that are not listed in the ASC fee schedule section of the *Medical Aid Rules and Fee Schedules* are not covered in an ASC.

ASCs will not receive payment for facility services for minor procedures that are commonly done in an office setting or treatment room. See the next paragraph for exceptions to this policy. The provider performing these procedures may still bill for the professional component.

Process to Obtain Approval for a Non-Covered Procedure

Under certain conditions, the director, the director's designee or Self-Insurer, at their sole discretion, may determine that a procedure not on the department's ASC procedure list may be authorized in an ASC. For example, this may occur when a procedure could be harmful to a particular patient unless performed in an ASC. Requests for coverage under these special circumstances require prior authorization.

The health care provider must submit a written request and obtain approval from the department or Self-Insurer prior to performing any procedure not on the ASC procedure list. The written request must contain a description of the proposed procedure with associated CPT® or HCPCS procedure codes, the reason for the request, the potential risks and expected benefits and the estimated cost of the procedure. The healthcare provider must provide any additional information about the procedure requested by the department or Self-Insurer.

ASC BILLING INFORMATION

Modifiers accepted for ASCs

-SG Ambulatory Surgical Center facility service

Modifier -SG may accompany all CPT® and HCPCS codes billed by an ASC. The department will accept modifiers listed in the CPT® and HCPCS books including those listed as approved for ASCs.

Modifiers affecting payment for ASCs

-50 Bilateral Modifier

Modifier -50 identifies cases where a procedure typically performed on one side of the body is performed on both sides of the body during the same operative session. Providers must bill using separate line items for each procedure performed. Modifier -50 must be applied to the second line item. The second line item will be paid at **50%** of the allowed amount for that procedure.

Example: Bilateral Procedure

Line item on bill	CPT® code/modifier	Maximum payment (Group 2)	Bilateral policy applied	Allowed amount
1	64721 -SG	$ 1,043.00		$ 1,043.00(1)
2	64721 -SG -50	$ 1,043.00	$ 521.50(2)	$ 521.50
Total allowed amount				$ **1,564.50**(3)

(1) First line item is paid at 100% of maximum allowed amount.
(2) When applying the bilateral payment policy the second line item billed with a modifier -50 is paid at 50% of the maximum allowed amount for that line item.
(3) Represents total allowable amount.

-51 Multiple surgery

Modifier -51 identifies when multiple surgeries are performed on the same patient at the same operative session. Providers must bill using separate line items for each procedure performed. Modifier -51 should be applied to the second line item. The total payment equals the sum of:

100% of the maximum allowable fee for the highest valued procedure according to the fee schedule, plus

50% of the maximum allowable fee for the subsequent procedures with the next highest values according to the fee schedule.

Example: Multiple Procedures

Line item on bill	CPT® code/modifier	Maximum payment (Groups 4 & 2)	Multiple policy applied	Allowed amount
1	29881 -SG	$ 1,473.00		$ 1,473.00(1)
2	64721 -SG -51	$ 1,043.00	$ 521.50(2)	$ 521.50
Total allowed amount				$ **1994.50**(3)

(1) Highest valued procedure is paid at 100% of maximum allowed amount.
(2) When applying the multiple procedure payment policy the second line item billed with a modifier -51 is paid at 50% of the maximum allowed amount for that line item.
(3) Represents total allowable amount.

If the same procedure is performed on multiple levels the provider must bill using separate line items for each level.

-73 Discontinued procedures prior to the administration of anesthesia

Modifier -73 is used when a physician cancels a surgical procedure due to the onset of medical complications subsequent to the patient's preparation, but prior to the administration of anesthesia. Payment will be at **50%** of the maximum allowable fee. Multiple and bilateral procedure pricing will apply to this, if applicable.

-74 Discontinued procedures after administration of anesthesia

Modifier -74 is used when a physician terminates a surgical procedure due to the onset of medical complications after the administration of anesthesia or after the procedure was started. Payment will be at **100%** of the maximum allowable fee. Multiple and bilateral procedure pricing will apply to this, if applicable.

-99 Multiple modifiers

Modifier -99 must be used when more than four modifiers affect payment. Payment is based on the policy associated with each individual modifier that describes the actual services performed. For billing purposes only modifier -99 must go in the modifier column, with the individual descriptive modifiers that affect payment listed in the remarks section of the billing form.

Exception: **Procedure Codes assigned to ASC Payment Groups 12 and 14**

CPT® and HCPCS codes assigned to ASC Payment Group 12 and ASC Payment Group 14 are not subject to multiple procedure discounting. A listing of the codes and payment groups are available online at http://www.LNI.wa.gov/ClaimsInsurance/ProviderPay/FeeSchedules/default.asp.

Prosthetic Implants

Implants must be billed on a separate line. The department covers HCPCS implant codes L8500 through L8699. ASCs will be paid acquisition cost for implants.

Exception: L8603

HCPCS code L8603 has a maximum fee and pays the lesser of the maximum fee or acquisition cost.

Exception: Intraocular Lenses

Intraocular lenses, including new technology lenses, are bundled into the fee for the associated procedure. Please include the cost of the lens in the charge for the procedure. It is permissible to include a line on the bill with the HCPCS code for an intraocular lens (i.e., V2630, V2631 and V2632) and its associated cost for information purposes only.

Acquisition Costs Policy

The acquisition cost equals the wholesale cost plus shipping, handling and sales tax. These items must be billed together as one charge. For taxable items, an itemized listing of the cost plus sales tax may be attached to the bill but is not required.

Wholesale invoices for all supplies and materials must be retained in the provider's office files for a minimum of five years. A provider must submit a hard copy of the wholesale invoice to the department or Self-Insurer when an individual supply costs $150.00 or more, or upon request. The insurer may delay payment of the provider's bill if the insurer has not received this information.

Example: Procedure with Implant

Line item on bill	CPT® code/modifier	Maximum payment (Group 4)	Allowed amount
1	29851 -SG	$ 1,473.00	$ 1,473.00(1)
2	L8699	$ 150.00 (Acquisition cost)	$ 150.00(2)
Total allowed amount			$ **1,623.00**(3)

(1) Procedure is paid at 100% of maximum allowed amount.
(2) Represents the total of wholesale implant cost plus associated shipping, handling and taxes.
(3) Represents total allowable amount.

Spinal Injections

Injection procedures are billed in the same manner as all other surgical procedures with the following considerations:

1. For purposes of multiple procedure discounting, each procedure in a bilateral set is considered to be a single procedure.
2. For injection procedures which require the use of radiographic localization and guidance, ASCs must bill for the technical component of the radiologic CPT® code (e.g., 76005 -TC) to be paid for the operation of a fluoroscope or C-arm.
3. Maximum fees for the technical components of the radiologic CPT® codes are listed in the radiology section of the Professional Services Fee Schedule available online at http://www.LNI.wa.gov/ClaimsInsurance/ProviderPay/FeeSchedules/default.asp.

Example: Injection Procedures

Line item on bill	CPT® code/modifier	Maximum payment (Group 1)	Bilateral/Multiple policies applied	Allowed amount
1	64470 -SG	$ 778.00		$ 778.00(1)
2	64470 -SG -50	$ 778.00	$ 389.00(2)	$ 389.00
3	64472 -SG	$ 778.00	$ 389.00(3)	$ 389.00
4	64472 -SG -50	$ 778.00	$ 389.00(2)	$ 389.00
5	76005 -TC	$ 69.87		$ 69.87(4)
Total allowed amount				$**2,014.87**(5)

(1) Highest valued procedure is paid at 100% of maximum allowed amount.
(2) When applying the bilateral procedure payment policy the second line item billed with a modifier -50 is paid at 50% of the maximum allowed amount for that line item.
(3) The multiple procedure payment policy is applied to subsequent procedures billed on the same day and are paid at 50% of the maximum allowed amount for that line item.
(4) This is the fee schedule maximum allowed amount for the fluoroscopic localization and guidance.
(5) Represents total allowable amount.

Exception: HCPCS Code G0260

G0260 cannot accept modifier -50 or any other multiple procedure modifier.

ASC PAYMENTS FOR SERVICES

The department pays the lesser of the billed charge (the ASC's usual and customary fee) or the department's maximum allowed rate.

The department's rates are based on a modified version of the grouping system developed by Medicare for ASC services. Medicare's grouping system was originally intended to group procedures with similar resource use together into payment categories. The department has modified Medicare's grouping system to fit a workers' compensation population.

Surgical services have been divided into 14 payment groups, each with an associated maximum fee.

ASC Maximum Allowable Fee by Group Number (1)(2)

Group	Fee	Payment Method
1	$778.00	• Fee Based on Medicare Rate
2	$1,043.00	• Fee Based on Medicare Rate
3	$1,192.00	• Fee Based on Medicare Rate
4	$1,473.00	• Fee Based on Medicare Rate
5	$1,676.00	• Fee Based on Medicare Rate
6	$1,730.00	• Fee Based on Medicare Rate
7	$2,326.00	• Fee Based on Medicare Rate
8	$2,074.00	• Fee Based on Medicare Rate
9	$3,130.00	• Fee Based on Medicare Rate
10	$4,800.00	• Max Fee, CPT® Code 63030
11	BR	• BR – Codes allowed in APC not on ASC List
12	BR	• BR – HCPCS
13	BR	• BR – Codes considered inpatient by CMS
14	Max Fee	• Max Fee (e.g., CPT® Codes 72240, 76005 or L8603), Radiology.

(1) Some services that do not belong to a payment group have a maximum fee. Other allowed services that are not part of a payment group are paid BR.

(2) Payment groups and rates for allowed procedures are listed in the Ambulatory Surgery Center Fee Schedule.

BRAIN INJURY REHABILITATION SERVICES

Only programs accredited by the Commission on Accreditation of Rehabilitation Facilities (CARF) may provide post-acute brain injury rehabilitation services for injured workers. These services require prior authorization. Follow-up care is included in the cost of the full day or half-day program. This includes but is not limited to telephone calls, home visits and therapy assessments. See Provider Bulletins 98-02 and 98-04 for more information.

Non-hospital based programs must bill the following local codes:

Code	Description	Maximum Fee
8950H	Comprehensive brain injury evaluation	$ 3,664.77
8951H	Post-acute brain injury rehabilitation full day program, per day (minimum of 6 hours per day)	$ 654.42
8952H	Post-acute brain injury rehabilitation half day program, per day (minimum 4 hours per day)	$ 392.66

Hospital based programs must bill the following local revenue codes:

Code	Description	Maximum Fee
0014	Comprehensive brain injury evaluation	$ 3,664.77
0015	Post-acute brain injury rehabilitation full day program, per day (minimum of 6 hours per day)	$ 654.42
0016	Post-acute brain injury rehabilitation half day program, per day (minimum 4 hours per day)	$ 392.66

NURSING HOME, RESIDENTIAL AND HOSPICE CARE SERVICES

NURSING HOME AND RESIDENTIAL CARE

The department will only pay the following types of residential service providers:

- DSHS-licensed nursing homes
- DSHS-licensed and certified nursing facilities
- DSHS-licensed and certified skilled nursing facilities
- DSHS-licensed boarding homes
- DSHS-licensed and certified Adult Family Homes
- Special department-approved arrangements

Providers must obtain a separate provider number for each type of service provided. The insurer, on a case-by-case basis depending on the worker's needs, may approve group homes and other residential care settings. Assisted living services are not covered.

Adult Day Care service providers must individually bill the department using their individual provider numbers for services provided to injured workers. In order to be authorized by the department as a provider of Adult Day Care services to injured workers, the provider must furnish the department with a copy of the letter from DSHS approving the provider's status as an Adult Day Care provider.

HOSPICE CARE

L&I will only pay DSHS-licensed hospice care providers. Medically necessary skilled nursing care and custodial care are covered for the worker's accepted industrial injury or illness. Daily rate fees are negotiated between the facility and the insurer based on the Medicare rates for services provided. Occupational, physical and speech therapies are included in the daily rate and are not separately payable. Pharmacy and DME are payable when billed separately using appropriate HCPCS codes.

Programs must bill the following local codes:

Code	Description	Maximum Fee
8902H	Nursing home or Residential Care	BR
8906H	Facility hospice care	BR

Billing Tip

Inappropriate use of CPT® and HCPCS codes may delay payment. For example, billing for drugs or physical therapy using DME codes is an example of improper coding and will delay reimbursement while the claim is being investigated.

Appendices

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APPENDIX A
ENDOSCOPY FAMILIES

Do not rely solely on the descriptions given in the appendices for complete coding information. Refer to a current CPT® or HCPCS book for complete coding information.

Base	Family
29805	29806, 29807, 29819, 29820, 29821, 29822, 29823, 29824, 29825, and 29826
29830	29834, 29835, 29836, 29837 and 29838
29840	29843, 29844, 29845, 29846 and 29847
29860	29861, 29862 and 29863
29870	29871, 29873, 29874, 29875, 29876, 29877, 29879, 29880, 29881, 29882, 29883, 29884, 29885, 29886 and 29887
31505	31510, 31511, 31512 and 31513
31525	31527, 31528, 31529, 31530, 31535, 31540, 31560 and 31570
31526	31531, 31536, 31541, 31561 and 31571
31575	31576, 31577, 31578 and 31579
31622	31623, 31624, 31625, 31628, 31629, 31630, 31631, 31635, 31640, 31641 and 31645
43200	43201, 43202, 43204, 43205, 43215, 43216, 43217, 43219, 43220, 43226, 43227 and 43228
43235	43231, 43232, 43236, 43237, 43238, 43239, 43241, 43242, 43243, 43244, 43245, 43246, 43247, 43248, 43249, 43250, 43251, 43255, 43256, 43258 and 43259
43260	43240, 43261, 43262, 43263, 43264, 43265, 43267, 43268, 43269, 43271, and 43272
44360	44361, 44363, 44364, 44365, 44366, 44369, 44370, 44372 and 44373
44376	44377, 44378 and 44379
44388	44389, 44390, 44391, 44392, 44393, 44394 and 44397
45300	45303, 45305, 45307, 45308, 45309, 45315, 45317, 45320, 45321 and 45327
45330	45331, 45332, 45333, 45334, 45335, 45337, 45338, 45339, 45340 and 45345
45378	45379, 45380, 45381, 45382, 45383, 45384, 45385, 45386 and 45387
46600	46604, 46606, 46608, 46610, 46611, 46612, 46614 and 46615
47552	47553, 47554, 47555 and 47556
49320	38570, 49321, 49322, 49323, 58550, 58660, 58661, 58662, 58670, 58671, 58672 and 58673
50551	50555, 50557, 50559 and 50561
50570	50572, 50574, 50575, 50576, 50578 and 50580
50951	50953, 50955, 50957, 50959 and 50961
50970	50974 and 50976
52000	52001, 52007, 52010, 52204, 52214, 52224, 52234, 52235, 52240, 52250, 52260, 52265, 52270, 52275, 52276, 52277, 52281, 52282, 52283, 52285, 52290, 52300, 52301, 52305, 52310, 52315, 52317 and 52318, 52400
52005	52320, 52325, 52327, 52330, 52332, 52334, 52341, 52342, 52343 and 52344
52351	52345, 52346, 52347, 52352, 52353, 52354 and 52355
57452	57454,57455, 57456, 57460 and 57461
58555	58558, 58559, 58560, 58561, 58562 and 58563

APPENDIX B
BUNDLED SERVICES

Do not rely solely on the descriptions given in the appendices for complete coding information. Refer to a current CPT® or HCPCS book for complete coding information.

CPT® Code	Abbreviated Description
15850	Removal of sutures
20930	Spinal bone allograft
20936	Spinal bone autograft
22841	Insert spine fixation device
43752	Nasal/orogastic w/stent
78890	Nuclear medicine data proc
78891	Nuclear med data proc
90885	Psy evaluation of records
90887	Consultation with family
90889	Preparation of report
91123	Irrigate fecal impaction
92352	Special spectacles fitting
92353	Special spectacles fitting
92354	Special spectacles fitting
92355	Special spectacles fitting
92358	Eye prosthesis service
92371	Repair & adjust spectacles
92531	Spontaneous nystagmus study
92532	Positional nystagmus study
92533	Caloric vestibular test
92534	Optokinetic nystagmus
92605	Eval for nonspeech device rx
92606	Non-speech device service
92613	Endoscopy swallow tst (fees)
92615	Eval laryngoscopy sense tst
92617	Interprt fees/laryngeal test
93770	Measure venous pressure
94150	Vital capacity test
94760	Measure blood oxygen level
94761	Measure blood oxygen level
96545	Provide chemotherapy agent
97010	Hot or cold packs therapy
99000	Specimen handling
99001	Specimen handling
99002	Device handling
99024	Postop follow-up visit

CPT® Code	Abbreviated Description
99056	Non-office medical services
99058	Office emergency care
99078	Group health education
99090	Computer data analysis
99091	Collect/review data from pt
99100	Special anesthesia service
99116	Anesthesia with hypothermia
99135	Special anesthesia procedure
99140	Emergency anesthesia
99141	Sedation, iv/im or inhalant
99142	Sedation, oral/rectal/nasal
99173	Visual screening test
99358	Prolonged serv, w/o contact
99359	Prolonged serv, w/o contact
99374	Home health care supervision
99377	Hospice care supervision
99379	Nursing fac care supervision

HCPCS Code	Abbreviated Description
A0800	Amb trans 7pm-7am
A9900	Supply/accessory/service
G0008	Admin influenza virus vac
G0009	Admin pneumococcal vaccine
G0010	Admin hepatitis b vaccine
G0102	Prostate ca screening; dre
L9900	O&P supply/accessory/service
Q3031	Collagen Skin Test
R0076	Transport portable EKG
V5010	Assessment for hearing aid
V5011	Fit/orientation/check of hearing aid
V5020	Conformity evaluation
V5090	Hearing aid dispensing fee

APPENDIX C
BUNDLED SUPPLIES

Do not rely solely on the descriptions given in the appendices for complete coding information. Refer to a current CPT® or HCPCS book for complete coding information.

Items with an asterisk (*) are used as orthotics/prosthetics and may be paid separately for **permanent** conditions if they are provided in the physician's office. These items are not considered prosthetics if the condition is acute or temporary.

For example, Foley catheters and accessories for permanent incontinence or ostomy supplies for permanent conditions may be paid separately when provided in the physician's office. The Foley catheter used to obtain a urine specimen, used after surgery, or used to treat an acute obstruction would not be paid separately because it is treating a temporary problem. If a patient had an indwelling Foley catheter for permanent incontinence, and a problem developed which required the physician to replace the Foley, then the catheter would be considered a prosthetic/orthotic and would be paid separately.

Surgical dressings and other items dispensed for home use are separately payable when billed with local modifier –1S.

CPT® Code	Abbreviated Description
99070	Special supplies
99071	Patient education materials

HCPCS Code	Abbreviated Description
A4206	1 CC sterile syringe&needle
A4207	2 CC sterile syringe&needle
A4208	3 CC sterile syringe&needle
A4209	5+ CC sterile syringe&needle
A4211	Supp for self-adm injections
A4212	Non coring needle or stylet
A4213	20+ CC syringe only
A4215	Sterile needle
A4216	Sterile water/saline, 10 ml
A4217	Sterile water/saline, 500 ml
A4244	Alcohol or peroxide per pint
A4245	Alcohol wipes per box
A4246	Betadine/phisohex solution
A4247	Betadine/iodine swabs/wipes
A4248	Chlorhexidine antisept
A4253	Blood glucose/reagent strips
A4256	Calibrator solution/chips
A4257	Replace Lensshield Cartridge
A4258	Lancet device each
A4259	Lancets per box

HCPCS Code	Abbreviated Description
A4262	Temporary tear duct plug
A4263	Permanent tear duct plug
A4265	Paraffin
A4270	Disposable endoscope sheath
A4300	Cath impl vasc access portal
A4301	Implantable access syst perc
A4305	Drug delivery system >=50 ML
A4306	Drug delivery system <=5 ML
A4310	Insert tray w/o bag/cath
A4311	Catheter w/o bag 2-way latex
A4312	Cath w/o bag 2-way silicone
A4313	Catheter w/bag 3-way
A4314	Cath w/drainage 2-way latex
A4315	Cath w/drainage 2-way silcne
A4316	Cath w/drainage 3-way
A4320	Irrigation tray
A4322	Irrigation syringe
A4324	Male ext cath w/adh coating
A4325	Male ext cath w/adh strip
A4326*	Male external catheter

HCPCS Code	Abbreviated Description
A4327*	Fem urinary collect dev cup
A4328*	Fem urinary collect pouch
A4330	Stool collection pouch
A4331	Extension drainage tubing
A4332	Lubricant for cath insertion
A4333	Urinary cath anchor device
A4334	Urinary cath leg strap
A4335*	Incontinence supply
A4338*	Indwelling catheter latex
A4340*	Indwelling catheter special
A4344*	Cath indw foley 2 way silicn
A4346*	Cath indw foley 3 way
A4347*	Male external catheter
A4348	Male ext cath extended wear
A4351	Straight tip urine catheter
A4352	Coude tip urinary catheter
A4353	Intermittent urinary cath
A4354	Cath insertion tray w/bag
A4355	Bladder irrigation tubing
A4356*	Ext ureth clmp or compr dvc
A4357*	Bedside drainage bag
A4358*	Urinary leg bag
A4359*	Urinary suspensory w/o leg b
A4361*	Ostomy face plate
A4362*	Solid skin barrier
A4364*	Ostomy/cath adhesive
A4365*	Ostomy adhesive remover wipe
A4366*	Ostomy vent
A4367*	Ostomy belt
A4368*	Ostomy filter
A4369*	Skin barrier liquid per oz
A4371*	Skin barrier powder per oz
A4372*	Skin barrier solid 4x4 equiv
A4373*	Skin barrier with flange
A4375*	Drainable plastic pch w fcpl
A4376*	Drainable rubber pch w fcplt
A4377*	Drainable plstic pch w/o fp
A4378*	Drainable rubber pch w/o fp
A4379*	Urinary plastic pouch w fcpl
A4380*	Urinary rubber pouch w fcplt
A4381*	Urinary plastic pouch w/o fp
A4382*	Urinary hvy plstc pch w/o fp
A4383*	Urinary rubber pouch w/o fp

HCPCS Code	Abbreviated Description
A4384*	Ostomy faceplt/silicone ring
A4385*	Ost skn barrier sld ext wear
A4387*	Ost clsd pouch w att st barr
A4388*	Drainable pch w ex wear barr
A4389*	Drainable pch w st wear barr
A4390*	Drainable pch ex wear convex
A4391*	Urinary pouch w ex wear barr
A4392*	Urinary pouch w st wear barr
A4393*	Urine pch w ex wear bar conv
A4394*	Ostomy pouch liq deodorant
A4395*	Ostomy pouch solid deodorant
A4396	Peristomal hernia supprt blt
A4397	Irrigation supply sleeve
A4398*	Ostomy irrigation bag
A4399*	Ostomy irrig cone/cath w brs
A4400*	Ostomy irrigation set
A4402*	Lubricant per ounce
A4404*	Ostomy ring each
A4405*	Nonpectin based ostomy paste
A4406*	Pectin based ostomy paste
A4407*	Ext wear ost skn barr <=4sq"
A4408*	Ext wear ost skn barr >4sq"
A4409*	Ost skn barr w flng <=4 sq"
A4410*	Ost skn barr w flng >4sq"
A4413*	2 pc drainable ost pouch
A4414*	Ostomy sknbarr w flng <=4sq"
A4415*	Ostomy skn barr w flng >4sq"
A4416*	Ost pch clsd w barrier/filtr
A4417*	Ost pch w bar/bltinconv/fltr
A4418*	Ost pch clsd w/o bar w filtr
A4419*	Ost pch for bar w flange/flt
A4420*	Ost pch clsd for bar w lk fl
A4421*	Ostomy supply misc
A4422*	Ost pouch absorbent material
A4423*	Ost pch for bar w lk fl/fltr
A4424*	Ost pch drain w bar & filter
A4425*	Ost pch drain for barrier fl
A4426*	Ost pch drain 2 piece system
A4427*	Ost pch drain/barr lk flng/f
A4428*	Urine ost pouch w faucet/tap
A4429*	Urine ost pouch w bltinconv
A4430*	Ost urine pch w b/bltin conv
A4431*	Ost pch urine w barrier/tapv

HCPCS Code	Abbreviated Description
A4432*	Os pch urine w bar/fange/tap
A4433*	Urine ost pch bar w lock fln
A4434*	Ost pch urine w lock flng/ft
A4450	Non-waterproof tape
A4452	Waterproof tape
A4455	Adhesive remover per ounce
A4458	Reusable enema bag
A4462	Abdmnl drssng holder/binder
A4465	Non-elastic extremity binder
A4470	Gravlee jet washer
A4480	Vabra aspirator
A4521	Adult size diaper sm each
A4522	Adult size diaper med each
A4523	Adult size diaper lg each
A4524	Adult size diaper xl each
A4525	Adult size brief sm each
A4526	Adult size brief med each
A4527	Adult size brief lg each
A4528	Adult size brief xl each
A4533	Youth size diaper each
A4534	Youth size brief each
A4535	Disp incont liner/shield ea
A4536	Prot underwr wshbl any sz ea
A4537	Under pad reusable any sz ea
A4550	Surgical trays
A4556	Electrodes, pair
A4557	Lead wires, pair
A4558	Conductive paste or gel
A4647	Supp- paramagnetic contr mat
A4649	Surgical supplies
A4670	Auto blood pressure monitor
A4930	Sterile, gloves per pair
A5051*	Pouch clsd w barr attached
A5052*	Clsd ostomy pouch w/o barr
A5053*	Clsd ostomy pouch faceplate
A5054*	Clsd ostomy pouch w/flange
A5055*	Stoma cap
A5061*	Pouch drainable w barrier at
A5062*	Drnble ostomy pouch w/o barr
A5063*	Drain ostomy pouch w/flange
A5071*	Urinary pouch w/barrier
A5072*	Urinary pouch w/o barrier
A5073*	Urinary pouch on barr w/flng

HCPCS Code	Abbreviated Description
A5081*	Continent stoma plug
A5082*	Continent stoma catheter
A5093*	Ostomy accessory convex inse
A5102*	Bedside drain btl w/wo tube
A5105*	Urinary suspensory
A5112*	Urinary leg bag
A5113*	Latex leg strap
A5114*	Foam/fabric leg strap
A5119*	Skin barrier wipes box pr 50
A5121*	Solid skin barrier 6x6
A5122*	Solid skin barrier 8x8
A5126*	Disk/foam pad +or- adhesive
A5131*	Appliance cleaner
A6011	Collagen gel/paste wound fil
A6010	Collagen based wound filler
A6021	Collagen dressing <=16 sq in
A6022	Collagen drsg>6<=48 sq in
A6023	Collagen dressing >48 sq in
A6024	Collagen dsg wound filler
A6025	Silicone gel sheet, each
A6154	Wound pouch each
A6196	Alginate dressing <=16 sq in
A6197	Alginate drsg >16 <=48 sq in
A6198	alginate dressing > 48 sq in
A6199	Alginate drsg wound filler
A6200	Compos drsg <=16 no border
A6201	Compos drsg >16<=48 no bdr
A6202	Compos drsg >48 no border
A6203	Composite drsg <= 16 sq in
A6204	Composite drsg >16<=48 sq in
A6205	Composite drsg > 48 sq in
A6206	Contact layer <= 16 sq in
A6207	Contact layer >16<= 48 sq in
A6208	Contact layer > 48 sq in
A6209	Foam drsg <=16 sq in w/o bdr
A6210	Foam drg >16<=48 sq in w/o b
A6211	Foam drg > 48 sq in w/o brdr
A6212	Foam drg <=16 sq in w/border
A6213	Foam drg >16<=48 sq in w/bdr
A6214	Foam drg > 48 sq in w/border
A6215	Foam dressing wound filler
A6216	Non-sterile gauze<=16 sq in
A6217	Non-sterile gauze>16<=48 sq

HCPCS Code	Abbreviated Description
A6218	Non-sterile gauze > 48 sq in
A6219	Gauze <= 16 sq in w/border
A6220	Gauze >16 <=48 sq in w/bordr
A6221	Gauze > 48 sq in w/border
A6222	Gauze <=16 in no w/sal w/o b
A6223	Gauze >16<=48 no w/sal w/o b
A6224	Gauze > 48 in no w/sal w/o b
A6228	Gauze <= 16 sq in water/sal
A6229	Gauze >16<=48 sq in watr/sal
A6230	Gauze > 48 sq in water/salne
A6231	Hydrogel dsg<=16 sq in
A6232	Hydrogel dsg>16<=48 sq in
A6233	Hydrogel dressing >48 sq in
A6234	Hydrocolld drg <=16 w/o bdr
A6235	Hydrocolld drg >16<=48 w/o b
A6236	Hydrocolld drg > 48 in w/o b
A6237	Hydrocolld drg <=16 in w/bdr
A6238	Hydrocolld drg >16<=48 w/bdr
A6239	Hydrocolld drg > 48 in w/bdr
A6240	Hydrocolld drg filler paste
A6241	Hydrocolloid drg filler dry
A6242	Hydrogel drg <=16 in w/o bdr
A6243	Hydrogel drg >16<=48 w/o bdr
A6244	Hydrogel drg >48 in w/o bdr
A6245	Hydrogel drg <= 16 in w/bdr
A6246	Hydrogel drg >16<=48 in w/b
A6247	Hydrogel drg > 48 sq in w/b
A6248	Hydrogel drsg gel filler
A6250	Skin seal protect moisturizr
A6251	Absorpt drg <=16 sq in w/o b
A6252	Absorpt drg >16 <=48 w/o bdr
A6253	Absorpt drg > 48 sq in w/o b
A6254	Absorpt drg <=16 sq in w/bdr
A6255	Absorpt drg >16<=48 in w/bdr
A6256	Absorpt drg > 48 sq in w/bdr
A6257	Transparent film <= 16 sq in
A6258	Transparent film >16<=48 in

HCPCS Code	Abbreviated Description
A6259	Transparent film > 48 sq in
A6260	Wound cleanser any type/size
A6261	Wound filler gel/paste /oz
A6262	Wound filler dry form / gram
A6266	Impreg gauze no h20/sal/yard
A6402	Sterile gauze <= 16 sq in
A6403	Sterile gauze>16 <= 48 sq in
A6404	Sterile gauze > 48 sq in
A6407	Packing strips, non-impreg
A6410	Sterile eye pad
A6411	Non-sterile eye pad
A6412	Occlusive eye patch
A6441	Pad band w>=3” <5”/yd
A6442	Conform band n/s w<3”/yd
A6443	Conform band n/s w>=3”<5”/yd
A6444	Conform band n/s w>=5”/yd
A6445	Conform band s w <3”/yd
A6446	Conform band s w>=3” <5”/yd
A6447	Conform band s w >=5”/yd
A6448	Lt compres band <3”/yd
A6449	Lt compres band >=3” <5”/yd
A6450	Lt compres band >=5”/yd
A6451	Mod compr band w>=3”<5”/yd
A6452	High compr band w>=3”<5”yd
A6453	Self-adher band w <3”/yd
A6454	Self-adher band w>=3” <5”/yd
A6455	Self-adher band >=5”/yd
A6456	Zinc paste band w >=3”<5”/yd
A9900	Supply/accessory/service
E0230	Ice cap or collar
G0117	Glaucoma scrn hgh risk direc
G0118	Glaucoma scrn hgh risk direc
K0620	Tubular elastic dressing
L9900	O&P supply/accessory/service
T1500	Reusable diaper/pant

APPENDIX D
NON-COVERED CODES

Do not rely solely on the descriptions given in the appendices for complete coding information. Refer to a current CPT® or HCPCS book for complete coding information.

CPT® Code	Abbreviated Description
00326	Anesth, larynx/trach, < 1 yr
00529	Anesth, closed chest
00797	Anesth, surgery for obesity
00834	Anesth, hernia repair< 1 yr
00836	Anesth hernia repair preemie
00851	Anesth, tubal ligation
10021	Fna w/o image
10022	Fna w/image
11975	Insert contraceptive cap
11976	Removal of contraceptive cap
11977	Removal/reinsert contra cap
11980	Implant hormone pellet(s)
11981	Insert drug implant device
11982	Remove drug implant device
11983	Remove/insert drug implant
17340	Cryotherapy of skin
17360	Skin peel therapy
17380	Hair removal by electrolysis
20982	Ablate, bone tumor(s) perq
21685	Hyoid myotomy & suspension
22520	Percut vertebroplasty thor
22521	Percut vertebroplasty lumb
22522	Percut vertebroplasty addl
31520	Diagnostic laryngoscopy
31601	Incision of windpipe
33140	Heart revascularize (tmr)
35510	Artery bypass graft
35512	Artery bypass graft
35522	Artery bypass graft
35525	Artery bypass graft
35697	Reimplant artery each
36400	Drawing blood
36405	Drawing blood
36406	Drawing blood
36420	Establish access to vein
36440	Blood transfusion service
36450	Exchange transfusion service
36470	Injection therapy of vein

CPT® Code	Abbreviated Description
36471	Injection therapy of veins
36510	Insertion of catheter, vein
36511	Apheresis wbc
36512	Apheresis rbc
36513	Apheresis platelets
36514	Apheresis plasma
36515	Apheresis, adsorp/reinfuse
36516	Apheresis, selective
36555	Insert non-tunnel cv cath
36557	Insert tunneled cv cath
36560	Insert tunneled cv cath
36568	Insert tunneled cv cath
36570	Insert tunneled cv cath
36660	Insertion catheter, artery
36838	Dist revas ligation, hemo
37765	Phleb veins - extrem - to 20
37766	Phleb veins - extrem 20+
38204	Bl donor search management
38205	Harvest allogenic stem cells
38206	Harvest auto stem cells
38207	Cryopreserve stem cells
38208	Thaw preserved stem cells
38209	Wash harvest stem cells
38210	T-cell depletion of harvest
38211	Tumor cell deplete of harvst
38212	Rbc depletion of harvest
38213	Platelet deplete of harvest
38214	Volume deplete of harvest
38215	Harvest stem cell concentrte
38242	Lymphocyte infuse transplant
42820	Remove tonsils and adenoids
42825	Removal of tonsils
42830	Removal of adenoids
42835	Removal of adenoids
43313	Esophagoplasty congenital
43314	Tracheo-esophagoplasty cong
43842	Gastroplasty for obesity
43843	Gastroplasty for obesity

CPT® Code	Abbreviated Description
43846	Gastric bypass for obesity
43847	Gastric bypass for obesity
43848	Revision gastroplasty
44126	Enterectomy w/taper, cong
44127	Enterectomy w/o taper, cong
44128	Enterectomy cong, add-on
44970	Laparoscopy, appendectomy
44979	Laparoscope proc, app
46070	Incision of anal septum
46705	Repair of anal stricture
47370	Laparo ablate liver tumor rf
47371	Laparo ablate liver cryosurg
47380	Open ablate liver tumor rf
47381	Open ablate liver tumor cryo
47382	Percut ablate liver rf
49419	Insrt abdom cath for chemotx
49491	Repair ing hern premie reduct
49492	Rpr ing hern premie, blocked
49495	Repair inguinal hernia, init
49496	Repair inguinal hernia, init
49500	Repair inguinal hernia
49501	Repair inguinal hernia, init
49580	Repair umbilical hernia
49582	Repair umbilical hernia
50541	Laparo ablate renal cyst
50542	Laparo ablate renal mass
50545	Laparo radical nephrectomy
50562	Renal scope w/tumor resect
50945	Laparoscopy ureterolithotomy
50947	Laparo new ureter/bladder
50948	Laparo new ureter/bladder
53025	Incision of urethra
54000	Slitting of prepuce
54150	Circumcision
54160	Circumcision
54162	Lysis penil circumcis lesion
54163	Repair of circumcision
54164	Frenulotomy of penis
54692	Laparoscopy, orchiopexy
55873	Cryoablate prostate
55970	Sex transformation, M to F
55980	Sex transformation, F to M
57155	insert uteri tandems/ovoids
58146	Myomectomy abdom complex
58300	Insert intrauterine device

CPT® Code	Abbreviated Description
58301	Remove intrauterine device
58321	Artificial insemination
58322	Artificial insemination
58323	Sperm washing
58346	Insert Heyman uteri capsule
58353	Endometr ablate, thermal
58545	Laparoscopic myomectomy
58546	Laparo-myomectomy, complex
58600	Division of fallopian tube
58605	Division of fallopian tube
58611	Ligate oviduct(s) add-on
58615	Occlude fallopian tube(s)
58953	Tah, rad dissect for debulk
58954	Tah rad debulk/lymph remove
58970	Retrieval of oocyte
58974	Transfer of embryo
58976	Transfer of embryo
59871	Remove cerclage suture
61000	Remove cranial cavity fluid
61001	Remove cranial cavity fluid
61517	Implt brain chemotx add-on
61863	Implant neuroelectrode
61864	Implant neuroelectrde, add'l
61867	Implant neuroelectrode
61868	Implant neuroelectrde, add'l
62164	Remove brain tumor w/scope
62165	Remove pituit tumor w/scope
62280	Treat spinal cord lesion
62287	Percutaneous diskectomy
62350	Implant spinal canal cath
62351	Implant spinal canal cath
62355	Remove spinal canal catheter
62360	Insert spine infusion device
62361	Implant spine infusion pump
62362	Implant spine infusion pump
62365	Remove spine infusion device
62367	Analyze spine infusion pump
62368	Analyze spine infusion pump
63650	Implant neuroelectrodes
63655	Implant neuroelectrodes
63660	Revise/remove neuroelectrode
63685	Implant neuroreceiver
63688	Revise/remove neuroreceiver
64561	Implant neuroelectrodes
64581	Implant neuroelectrodes
64614	Destroy nerve, extrem musc
65771	Radial keratotomy

CPT® Code	Abbreviated Description
69090	Pierce earlobes
70557	Mri brain w/o dye
70558	Mri brain w/ dye
70559	Mri brain w/o & w/ dye
73592	X-ray exam of leg, infant
76012	Percut vertebroplasty fluor
76013	Percut vertebroplasty, ct
76082	Computer mammogram add-on
76083	Computer mammogram add-on
76140	X-ray consultation
76885	Echo exam, infant hips
76886	Echo exam, infant hips
76940	Us guide, tissue ablation
77301	Radiotherapy dose plan, imrt
77418	Radiation tx delivery, imrt
78459	Heart muscle imaging (PET)
78491	Heart image (pet), single
78492	Heart image (pet), multiple
78608	Brain imaging (PET)
78609	Brain imaging (PET)
78804	Tumor imaging, whole body
78810	Tumor imaging (PET)
79403	Hematopoetic nuclear therapy
82523	Collagen crosslinks
83950	Oncoprotein, HER-2/NEU
84591	Assay of nos vitamin
84830	Ovulation tests
85055	Reticulated platelet assay
86146	Glycoprotein antibody
86336	Inhibin A
86910	Blood typing, paternity test
86911	Blood typing, antigen system
87339	H pylori ag, eia
87427	Shiga-like toxin ag, eia
87660	Trichomonas vagin, dir probe
88012	Autopsy (necropsy), gross
88014	Autopsy (necropsy), gross
88016	Autopsy (necropsy), gross
88028	Autopsy (necropsy), complete
88029	Autopsy (necropsy), complete
88112	Cytopath, cell enhance tech
88361	Immunohistochemistry, tumor
88380	Microdissection
88400	Bilirubin total transcut
89250	Fertilization of oocyte
89251	Culture oocyte w/embryos
89253	Embryo hatching

CPT® Code	Abbreviated Description
89254	Oocyte identification
89255	Prepare embryo for transfer
89257	Sperm identification
89258	Cryopreservation, embryo
89259	Cryopreservation, sperm
89260	Sperm isolation, simple
89261	Sperm isolation, complex
89268	Insemination of oocytes
89272	Extended culture of oocytes
89280	Assist oocyte fertilization
89281	Assist oocyte fertilization
89290	Biopsy, oocyte polar body
89291	Biopsy, oocyte polar body
89335	Cryopreserve testicular tiss
89342	Storage/year; embryo(s)
89343	Storage/year; sperm/semen
89344	Storage/year; reprod tissue
89346	Storage/year; oocyte
89352	Thawing cryopresrved; embryo
89353	Thawing cryopresrved; sperm
89354	Thaw cryoprsvrd; reprod tiss
89356	Thawing cryopresrved; oocyte
90283	Human ig, iv
90288	Botulism ig, iv
90378	Rsv ig, im
90379	Rsv ig, iv
90473	Immunization admin, intra
90474	Immunization adm, each add
90476	Adenovirus vaccine, type 4
90477	Adenovirus vaccine, type 7
90581	Anthrax vaccine, sc
90632	Hep a vaccine, adult im
90633	Hep a vacc, ped/adol, 2 dose
90634	Hep a vacc, ped/adol, 3 dose
90636	Hep a/hep b vacc, adult im
90645	Hib vaccine, hboc, im
90646	Hib vaccine, prp-d, im
90647	Hib vaccine, prp-omp, im
90648	Hib vaccine, prp-t, im
90655	Flu vaccine, 6-35 mo, im
90656	Flu vaccine, > 3 yrs, im
90657	Flu vaccine, 6-35 mo, im
90658	Flu vaccine, 3 yrs, im
90660	Flu vaccine, nasal
90669	Pneumococcal vaccine, ped
90680	Rotovirus vaccine, oral

CPT® Code	Abbreviated Description
90690	Typhoid vaccine, oral
90691	Typhoid vaccine, im
90692	Typhoid vaccine, h-p, sc/id
90693	Typhoid vaccine, akd, sc
90698	Dtap-hib-ip vaccine, im
90700	Dtap vaccine, im
90710	Mmrv vaccine, sc
90715	Tdap vaccine >7 im
90719	Diphtheria vaccine, im
90720	Dtp/hib vaccine, im
90721	Dtap/hib vaccine, im
90723	Dtap-hep b-ipv vaccine, im
90725	Cholera vaccine
90727	Plague vaccine, im
90734	Meningococcal vaccine, im
90744	Hep b vaccine, ped/adol, im
90748	Hep b/hib vaccine, im
90802	Intac psy dx interview
90810	Intac psytx, off, 20-30 min
90811	Intac psytx, 20-30, w/e&m
90812	Intac psytx, off, 45-50 min
90813	Intac psytx, 45-50 min w/e&m
90814	Intac psytx, off, 75-80 min
90815	Intac psytx, 75-80 w/e&m
90823	Intac psytx, hosp, 20-30 min
90824	Intac psytx, hsp 20-30 w/e&m
90826	Intac psytx, hosp, 45-50 min
90827	Intac psytx, hsp 45-50 w/e&m
90828	Intac psytx, hosp, 75-80 min
90829	Intac psytx, hsp 75-80 w/e&m
90845	Psychoanalysis
90846	Family psytx w/o patient
90849	Multiple family group psytx
90857	Intac group psytx
90918	ESRD related services, month
90919	ESRD related services, month
90922	ESRD related services, day
90923	Esrd related services, day
91132	Electrogastrography
91133	Electrogastrography w/test
92601	Cochlear implt f/up exam < 7
92602	Reprogram cochlear implt < 7
93530	Rt heart cath, congenital

CPT® Code	Abbreviated Description
93531	R & l heart cath, congenital
93532	R & l heart cath, congenital
93533	R & l heart cath, congenital
93580	Transcath closure of asd
93581	Transcath closure of vsd
93740	Temperature gradient studies
93760	Cephalic thermogram
93762	Peripheral thermogram
95120	Immunotherapy, one injection
95125	Immunotherapy, many antigens
95130	Immunotherapy, insect venom
95131	Immunotherapy, insect venoms
95132	Immunotherapy, insect venoms
95133	Immunotherapy, insect venoms
95134	Immunotherapy, insect venoms
95250	Glucose monitoring, cont
95970	Analyze neurostim, no prog
95971	Analyze neurostim, simple
95972	Analyze neurostim, complex
95973	Analyze neurostim, complex
95974	Cranial neurostim, complex
95975	Cranial neurostim, complex
96567	Photodynamic tx, skin
96570	Photodynamic tx, 30 min
96571	Photodynamic tx, addl 15 min
95990	Spin/brain pump refil & main
95991	Spin/brain pump refil & main
96902	Trichogram
96920	Laser tx, skin < 250 sq cm
96921	Laser tx, skin 250-500 sq cm
96922	Laser tx, skin > 500 sq cm
97005	Athletic train eval
97006	Athletic train reeval
97033	Electric current therapy
97545	Work hardening
97546	Work hardening add-on
97780	Acupuncture w/o stimul
97781	Acupuncture w/stimul
98940	Chiropractic manipulation
98941	Chiropractic manipulation
98942	Chiropractic manipulation
98943	Chiropractic manipulation
99026	In-hospital on call service

CPT® Code	Abbreviated Description
99027	Out-of-hosp on call service
99075	Medical testimony
99170	Anogenital exam, child
99289	Ped crit care transport
99290	Ped crit care transport addl
99293	Ped critical care, initial
99294	Ped critical care, subseq
99295	Neonatal critical care
99296	Neonatal critical care
99298	Neonatal critical care
99299	Ic, lbw infant 1500-2500 gm
99381	Prev visit, new, infant
99382	Prev visit, new, age 1-4
99383	Prev visit, new, age 5-11
99384	Prev visit, new, age 12-17
99385	Prev visit, new, age 18-39
99386	Prev visit, new, age 40-64
99387	Prev visit, new, 65 & over
99391	Prev visit, est, infant
99392	Prev visit, est, age 1-4
99393	Prev visit, est, age 5-11
99394	Prev visit, est, age 12-17
99395	Prev visit, est, age 18-39
99396	Prev visit, est, age 40-64
99397	Prev visit, est, 65 & over
99401	Preventive counseling, indiv
99402	Preventive counseling, indiv
99403	Preventive counseling, indiv
99404	Preventive counseling, indiv
99411	Preventive counseling, group
99412	Preventive counseling, group
99420	Health risk assessment test
99429	Unlisted preventive service
99431	Initial care, normal newborn
99432	Newborn care, not in hosp
99433	Normal newborn care/hospital
99435	Newborn discharge day hosp
99436	Attendance, birth
99440	Newborn resuscitation
99450	Life/disability evaluation
99455	Disability examination
99456	Disability examination
99500	Home visit, prenatal

CPT® Code	Abbreviated Description
99501	Home visit, postnatal
99502	Home visit, nb care
99503	Home visit, resp therapy
99504	Home visit mech ventilator
99505	Home visit, stoma care
99506	Home visit, IM injection
99507	Home visit, cath maintain
99509	Home visit day life activity
99510	Home visit, sing/m/fam couns
99511	Home visit, fecal/enema mgmt
99512	Home visit, hemodialysis
99600	Home visit nos
99601	Home infusion/visit, 2 hrs
99602	Home infusion, each addtl hr
0003T	Cervicography
0009T	Endometrial Cryoblation
0017T	Destruction of macular drusen, photocoa
0019T	Extracorp shock wave tx, msc
0020T	Extracorp shock wave tx, ft
0024T	Non-surgical septal reduction therapy
0026T	Lipoprotein, direct measurement, interm
0028T	Ultrasonic pachymetry
0030T	Antiprothrombin antibody
0031T	Speculoscopy
0032T	Speculoscopy w/direct sample
0044T	Whole body photography
0045T	Whole body integumentary photo
0046T	Catheter lavage, single duct
0047T	Catheter lavage, each addl duct
0057T	Uppr gi scope w/ thrml txmnt
0058T	Cryopreservation, ovary tiss
0059T	Cryopreservation, oocyte
0060T	Electrical impedance scan
0061T	Destruction of tumor, breast

HCPCS Code	Abbreviated Description
A0432	PI volunteer ambulance co
A0888	Noncovered ambulance mileage
A4220	Infusion pump refill kit
A4260	Levonorgestrel implant
A4261	Cervical cap contraceptive
A4266	Diaphragm
A4267	Male condom
A4268	Female condom
A4269	Spermicide
A4281	Replacement breastpump tube
A4282	Replacement breastpump adpt
A4283	Replacement breastpump cap
A4284	Replcmnt breast pump shield
A4285	Replcmnt breast pump bottle
A4286	Replcmnt breastpump lok ring
A4529	Child size diaper sm/med ea
A4530	Child size diaper lg each
A4531	Child size brief sm/med each
A4532	Child size brief lg each
A4538	Diaper sv ea reusable diaper
A4561	Pessary rubber, any type
A4562	Pessary, non rubber,any type
A4570	Splint
A4580	Cast supplies (plaster)
A4590	Special casting material
A4633	Uvl replacement bulb
A4634	Replacement bulb th lightbox
A4638	Repl batt pulse gen sys
A4639	Infrared ht sys replcmnt pad
A4931	Reusable oral thermometer
A4932	Reusable rectal thermometer
A7025	Replace chest compress vest
A7026	Replace chst cmprss sys hose
A7030	CPAP full face mask
A7031	Replacement facemask interfa
A7032	Replacement nasal cushion
A7033	Replacement nasal pillows
A7034	Nasal application device
A7035	Pos airway press headgear
A7036	Pos airway press chinstrap
A7037	Pos airway pressure tubing
A7038	Pos airway pressure filter
A7039	Filter, non disposable w pap

HCPCS Code	Abbreviated Description
A7044	PAP oral interface
A9270	Non-covered item or service
A9300	Exercise equipment
C1775	FDG, per dose (4-40 mCi/ml)
C2614	Probe, perc lumb disc
C2632	Brachytx sol, I-125, per mCi
C9117	Injection, yttrium 90
C9118	Injection, indium111
C9119	Injection, pegfilgrastim
C9711	H.E.L.P. apheresis system
D0180	Comp periodontal evaluation
D1320	Tobacco counseling
D4241	Gngvl flap w rootplan 1-3 th
D4261	Osseous surgl-3teethperquad
D4342	Periodontal scaling 1-3teeth
D6985	Pediatric partial denture fx
D7411	Excision benign lesion>1.25c
D7412	Excision benign lesion compl
D7413	Excision malig lesion<=1.25c
D7414	Excision malig lesion>1.25cm
D7415	Excision malig les complicat
D7472	Removal of torus palatinus
D7473	Remove torus mandibularis
D7485	Surg reduct osseoustuberosit
D7972	Surg redct fibrous tuberosit
D9999	Adjunctive procedure
E0190	Positioning cushion
E0200	Heat lamp without stand
E0202	Phototherapy light w/ photom
E0203	Therapeutic lightbox tabletp
E0205	Heat lamp with stand
E0210	Electric heat pad standard
E0215	Electric heat pad moist
E0217	Water circ heat pad w pump
E0218	Water circ cold pad w pump
E0220	Hot water bottle
E0221	Infrared heating pad system
E0225	Hydrocollator unit
E0236	Pump for water circulating p
E0238	Heat pad non-electric moist
E0239	Hydrocollator unit portable
E0249	Pad water circulating heat u
E0300	Enclosed ped crib hosp grade
E0500	Ippb all types

HCPCS Code	Abbreviated Description
E0590	Dispensing fee dme neb drug
E0602	Breast pump
E0603	Electric breast pump
E0604	Hosp grade elec breast pump
E0618	Apnea monitor
E0619	Apnea monitor w recorder
E0691	Uvl pnl 2 sq ft or less
E0692	Uvl sys panel 4 ft
E0693	Uvl sys panel 6 ft
E0694	Uvl md cabinet sys 6 ft
E0720	TENS two lead
E0731	Conductive garment for tens
E0740	Incontinence treatment systm
E0744	Neuromuscular stim for scoli
E0748	Elec osteogen stim spinal
E0752	Neurostimulator electrode
E0754	Pulsegenerator pt programmer
E0755	Electronic salivary reflex s
E0756	Implantable pulse generator
E0757	Implantable RF receiver
E0758	External RF transmitter
E0765	Nerve stimulator for tx n&v
E0782	Non-programble infusion pump
E0783	Programmable infusion pump
E0785	Replacement impl pump cathet
E0786	Implantable pump replacement
E0941	Gravity assisted traction de
E1011	Ped wc modify width adjustm
E1012	Int seat sys planar ped w/c
E1013	Int seat sys contour ped w/c
E1014	Reclining back add ped w/c
E1025	Pedwc lat/thor sup nocontour
E1026	Pedwc contoured lat/thor sup
E1027	Ped wc lat/ant support
E1037	Transport chair, ped size
E1231	Rigid ped w/c tilt-in-space
E1232	Folding ped wc tilt-in-space
E1233	Rig ped wc tltnspc w/o seat
E1234	Fld ped wc tltnspc w/o seat
E1235	Rigid ped wc adjustable
E1236	Folding ped wc adjustable
E1237	Rgd ped wc adjstabl w/o seat
E1238	Fld ped wc adjstabl w/o seat

HCPCS Code	Abbreviated Description
E2120	Pulse gen sys tx endolymp fl
G0030	PET imaging prev PET single
G0031	PET imaging prev PET multple
G0032	PET follow SPECT 78464 singl
G0033	PET follow SPECT 78464 mult
G0034	PET follow SPECT 76865 singl
G0035	PET follow SPECT 78465 mult
G0036	PET follow cornry angio sing
G0037	PET follow cornry angio mult
G0038	PET follow myocard perf sing
G0039	PET follow myocard perf mult
G0040	PET follow stress echo singl
G0041	PET follow stress echo mult
G0042	PET follow ventriculogm sing
G0043	PET follow ventriculogm mult
G0044	PET following rest ECG singl
G0045	PET following rest ECG mult
G0046	PET follow stress ECG singl
G0047	PET follow stress ECG mult
G0110	Nett pulm-rehab educ; ind
G0111	Nett pulm-rehab educ; group
G0112	Nett; nutrition guid, initial
G0113	Nett; nutrition guid,subseqnt
G0114	Nett; psychosocial consult
G0115	Nett; psychological testing
G0116	Nett; psychosocial counsel
G0125	Lung image (PET)
G0128	CORF skilled nursing service
G0129	Occ therapy, partial hosp
G0154	Svcs of skilled nurse under hm hlth, ea 15 min
G0155	Svcs of clin soc wkr under hm hlth, ea 15 min
G0176	OPPS/PHP;activity therapy
G0179	MD recert HHA patient
G0180	MD certification HHA patient
G0181	Home health care supervision
G0182	Hospice care supervision
G0210	PET img wholebody dxlung ca
G0211	PET img wholebody init lung
G0212	PET img wholebod restag lung
G0213	PET img wholebody dx colorec
G0214	PET img wholebody init colore

HCPCS Code	Abbreviated Description
G0215	PETimg wholebod restag colre
G0216	PET img wholebod dx melanoma
G0217	PET img wholbod init melano
G0218	PET img wholebod restag mela
G0219	PET img wholbod melano non-co
G0220	PET img wholebod dx lymphoma
G0221	PET imag wholbod init lympho
G0222	PET imag wholbod resta lymph
G0223	PET imag wholbod reg dx head
G0224	PET imag wholbod reg ini hea
G0225	PET whol restag headneck only
G0226	PET img wholbod dx esophagl
G0227	PET img wholbod ini esophage
G0228	PET img wholbod restg esopha
G0229	PET img metabolic brain pres
G0230	PET myocard viability post s
G0231	PET WhBD colorec; gamma cam
G0232	PET WhBD lymphoma; gamma cam
G0233	PET WhBD melanoma; gamma cam
G0234	PET WhBD pulm nod; gamma cam
G0242	Multisource photon ster plan
G0243	Multisour photon stero treat
G0245	Initial foot exam ptlops
G0246	Followup eval of foot pt lop
G0247	Routine footcare pt w lops
G0251	Stereotactic radiosurgery
G0252	PET imaging
G0253	PET imaging
G0254	PET imaging
G0255	Current percep threshold tst
G0265	Cryopresevation Freeze+stora
G0266	Thawing + expansion froz cel
G0267	Bone marrow or psc harvest
G0268	Removal of impacted wax md
G0270	MNT subs tx for change dx
G0271	Group MNT 2 or more 30 mins
G0279	Excorp shock tx, elbow epi
G0280	Excorp shock tx oth
G0283	Elec stim other than wound
G0290	Drug-eluting stents, single
G0291	Drug-eluting stents,each add
G0292	Adm exp drugs,clinical trial
G0293	Non-cov surg proc,clin trial

HCPCS Code	Abbreviated Description
G0294	Non-cov proc, clinical trial
G0295	Electromagnetic therapy onc
G0296	PET imge restag thyrod cance
G0308	ESRD related svc 4+mo<2yrs
G0309	ESRD related svc 2-3mo<2yrs
G0310	ESRD related svc 1 visit<2yr
G0311	ESRD related svs 4+mo 2-11yr
G0312	ESRD relate svs 2-3 mo 2-11y
G0313	ESRD related svs 1 mon 2-11y
G0314	ESRD related svs 4+ mo 12-19
G0315	ESRD related svs 2-3mo 12-19
G0316	ESRD relate svs 1 vist 12-19
G0320	ESRD related svs home under2
G0321	ESRD related svs home mo<2ys
G0322	ESRD relate svs home mo12-19
G0324	ESRD related svs home/dy<2y
G0325	ESRD relate home/dy 2-11 yr
G0326	ESRD relate home/dy 12-19y
G0328	Fecal blood screening immunoassay.
G3001	Admin + supply, tositumomab
G9002	MCCD,maintenance rate
G9003	MCCD, risk adj hi, initial
G9004	MCCD, risk adj lo, initial
G9016	Demo-smoking cessation coun
H0016	Alcohol and/or drug services
H0021	Alcohol and/or drug training
H0022	Alcohol and/or drug interven
H0023	Alcohol and/or drug outreach
H0024	Alcohol and/or drug preventi
H0025	Alcohol and/or drug preventi
H0026	Alcohol and/or drug preventi
H0027	Alcohol and/or drug preventi
H0028	Alcohol and/or drug preventi
H0029	Alcohol and/or drug preventi
H0030	Alcohol and/or drug hotline
H0031	MH health assess by non-md
H0032	MH svc plan dev by non-md
H0033	Oral med adm direct observe
H0034	Med trng & support per 15min
H0035	MH partial hosp tx under 24h
H0036	Comm psy face-face per 15min
H0037	Comm psy sup tx pgm per diem
H0038	Self-help/peer svc per 15min

HCPCS Code	Abbreviated Description
H0039	Asser com tx face-face/15min
H0040	Assert comm tx pgm per diem
H0041	Fos c chld non-ther per diem
H0042	Fos c chld non-ther per mon
H0043	Supported housing, per diem
H0044	Supported housing, per month
H0045	Respite not-in-home per diem
H0046	Mental health service, nos
H1010	Nonmed family planning ed
H1011	Family assessment
H2000	Comp multidisipln evaluation
H2001	Rehabilitation program 1/2 d
H2010	Comprehensive med svc 15 min
H2011	Crisis interven svc, 15 min
H2012	Behav Hlth Day Treat, per hr
H2013	Psych hlth fac svc, per diem
H2014	Skills Train and Dev, 15 min
H2015	Comp Comm Supp Svc, 15 min
H2016	Comp Comm Supp Svc, per diem
H2017	PsySoc Rehab Svc, per 15 min
H2018	PsySoc Rehab Svc, per diem
H2019	Ther Behav Svc, per 15 min
H2020	Ther Behav Svc, per diem
H2021	Com Wrap-Around Sv, 15 min
H2022	Com Wrap-Around Sv, per diem
H2023	Supported Employ, per 15 min
H2024	Supported Employ, per diem
H2025	Supp Maint Employ, 15 min
H2026	Supp Maint Employ, per diem
H2027	Psychoed Svc, per 15 min
H2028	Sex Offend Tx Svc, 15 min
H2029	Sex Offend Tx Svc, per diem
H2030	MH Clubhouse Svc, per 15
H2031	MH Clubhouse Svc, per diem
H2032	Activity Therapy, per 15 min
H2033	Multisys Ther/Juvenile 15min
H2034	A/D Halfway House, per diem
H2035	A/D Tx Program, per hour
H2036	A/D Tx Program, per diem
H2037	Dev Delay Prev Dp Ch, 15 min
J0190	Injection, biperiden, 2 mg
J0215	Alefacept
J0583	Bivalirudin

HCPCS Code	Abbreviated Description
J0636	Inj calcitriol per 0.1 mcg
J0706	Caffeine citrate injection
J0760	Colchicine injection
J0880	Darbepoetin alfa injection
J0970	Estradiol valerate injection
J1000	Depo-estradiol cypionate inj
J1051	Medroxyprogesterone inj
J1055	Medrxyprogester acetate inj
J1056	MA/EC contraceptiveinjection
J1270	Injection, doxercalciferol
J1330	Ergonovine maleate injection
J1380	Estradiol valerate 10 MG inj
J1390	Estradiol valerate 20 MG inj
J1410	Inj estrogen conjugate 25 MG
J1435	Injection estrone per 1 MG
J1565	RSV-ivig
J1595	Injection glatiramer acetate
J1756	Iron sucrose injection
J1890	Cephalothin sodium injection
J2210	Methylergonovin maleate inj
J2271	Morphine so4 injection 100mg
J2324	Nesiritide
J2501	Paricalcitol
J2505	Injection, pegfilgrastim 6mg
J2590	Oxytocin injection
J2675	Progesterone Injection
J2765	Injection, metoclopramide hcl
J2783	Rasburicase
J2940	Somatrem injection
J2941	Somatropin injection
J3315	Triptorelin pamoate
J3364	Urokinase 5000 IU injection
J3395	Verteporfin injection
J3530	Nasal vaccine inhalation
J3570	Laetrile amygdalin vit B17
J7300	Intraut copper contraceptive
J7302	Levonorgestrel iu contracept
J7303	Contraceptive vaginal ring
J7308	Aminolevulinic acid hcl top
J7635	Atropine inhal sol con
J7636	Atropine inhal sol unit dose
J7637	Dexamethasone inhal sol con
J7638	Dexamethasone inhal sol u d

HCPCS Code	Abbreviated Description
J7642	Glycopyrrolate inhal sol con
J7643	Glycopyrrolate inhal sol u d
J7658	Isoproterenolhcl inh sol con
J7659	Isoproterenol hcl inh sol ud
J7680	Terbutaline so4 inh sol con
J7681	Terbutaline so4 inh sol u d
J7682	Tobramycin inhalation sol
J9010	Alemtuzumab injection
J9165	Diethylstilbestrol injection
J9219	Leuprolide acetate implant
J9395	Injection, Fulvestrant
K0606	AED garment w elec analysis
K0607	Repl batt for AED
K0608	Repl garment for AED
K0609	Repl electrode for AED
L1005	Tension based scoliosis orth
M0075	Cellular therapy
M0076	Prolotherapy
M0100	Intragastric hypothermia
M0300	IV chelationtherapy
M0301	Fabric wrapping of aneurysm
P2031	Hair analysis
P7001	Culture bacterial urine
P9604	One-way allow prorated trip
Q0035	Cardiokymography
Q0144	Azithromycin dihydrate, oral
Q2001	Oral cabergoline 0.5 mg
Q2002	Elliotts b solution per ml
Q2005	Corticorelin ovine triflutat
Q2007	Ethanolamine oleate 100 mg
Q2012	Pegademase bovine, 25 iu
Q2014	Sermorelin acetate, 0.5 mg
Q2018	Urofollitropin, 75 iu
Q3014	Telehealth facility fee
Q3025	IM inj interferon beta 1-a
Q3026	Subc inj interferon beta-1a
Q4007	Cast sup long arm ped, pl
Q4008	Cast sup, long arm ped, fib
Q4011	Cast sup sh arm ped, pl
Q4012	Cast sup sh arm ped, fib
Q4015	Cast sup gauntlet ped,
Q4016	Cast sup gauntlet ped, fib
Q4019	Cast sup l arm splint ped, pl

HCPCS Code	Abbreviated Description
Q4020	Cast sup l arm splint ped, fib
Q4023	Cast sup sh arm splint ped, pl
Q4024	Cast sup sh arm splint ped, fib
Q4027	Cast sup hip spica, pl
Q4028	Cast sup, hip spica, fib
Q4031	Cast sup, long leg ped, pl
Q4032	Cast sup, long leg ped, fib
Q4035	Cast sup, leg cylinder ped, pl
Q4036	Cast sup, leg cylinder ped, fib
Q4039	Cast sup, sh leg ped, pl
Q4040	Cast sup, sh leg ped, fib
Q4043	Cast sup, l leg splintped, pl
Q4044	Cast sup, l leg splint ped, fib
Q4047	Cast sup, sh leg splint ped, pl
Q4048	Cast sup, sh leg splint ped, fib
Q4077	Treprostinil, 1 mg
S0012	Butorphanol tartrate, nasal
S0014	Tacrine hydrochloride, 10 mg
S0016	Injection, amikacin sulfate
S0017	Injection, aminocaproic acid
S0020	Injection, bupivicaine hydro
S0021	Injection, ceftoperazone sod
S0023	Injection, cimetidine hydroc
S0028	Injection, famotidine, 20 mg
S0030	Injection, metronidazole
S0032	Injection, nafcillin sodium
S0034	Injection, ofloxacin, 400 mg
S0039	Injection, sulfamethoxazole
S0040	Injection, ticarcillin disod
S0071	Injection, acyclovir sodium
S0072	Injection, amikacin sulfate
S0073	Injection, aztreonam, 500 mg
S0074	Injection, cefotetan disodiu
S0077	Injection, clindamycin phosp
S0078	Injection, fosphenytoin sodi
S0080	Injection, pentamidine iseth
S0081	Injection, piperacillin sodi
S0090	Sildenafil citrate, 25 mg
S0104	Zidovudine, oral, 100 mg
S0106	Bupropion hcl sr 60 tablets
S0107	Inj, omalizumab 25 mg
S0108	Mercaptopurine 50 mg
S0114	Treprostinil sodium inject

HCPCS Code	Abbreviated Description
S0122	Inj menotropins 75 iu
S0126	Inj follitropin alfa 75 iu
S0128	Inj follitropin beta 75 iu
S0132	Inj ganirelix acetat 250 mcg
S0136	Clozapine, 25 mg
S0137	Didanosine, 25 mg
S0138	Finasteride, 5 mg
S0139	Minoxidil, 10 mg
S0140	Saquinavir, 200 mg
S0141	Zalcitabine, 0.375 mg
S0156	Exemestane, 25 mg
S0157	Becaplermin gel 1%, 0.5 gm
S0158	Injection laronidase
S0159	Injection agalsidase
S0160	Dextroamphetamine
S0161	Calcitriol
S0162	Injection efalizumab
S0165	Injection abarelix
S0194	Vitamin suppl 100 caps
S0195	Pneumococcal conjugate vac
S0199	RU486 Professional Fee
S0201	Prt hosp svcs, less than 24 hrs, per diem
S0207	Parmedic intercept, non-hosp based
S0208	Paramed intrcept nonvol
S0209	WC van mileage per mi
S0215	Nonemerg transp mileage
S0220	Medical conference by physic
S0221	Medical conference, 60 min
S0250	Comp geriatr assmt team
S0255	Hospice refer visit nonmd
S0260	H&P for surgery
S0302	Completed EPSDT
S0310	Hospitalist visit
S0315	Disease mgmt prgrm, init
S0316	Disease mgmt prgrm, flw up
S0317	Disease mgmt per diem
S0320	Phone call by RN to dis mgmt prgrm
S0340	Lifestyle mod 1st stage
S0341	Lifestyle mod 2 or 3 stage
S0342	Lifestyle mod 4th stage
S0390	Rout foot care per visit
S0400	Global eswl kidney
S0500	Dispos cont lens

HCPCS Code	Abbreviated Description
S0504	Singl prscrp lens
S0506	Bifoc prscp lens
S0508	Trifoc prscrp lens
S0510	Non-prscrp lens
S0512	Daily cont lens
S0514	Color cont lens
S0516	Safety frames
S0518	Sunglass frames
S0580	Polycarb lens
S0581	Nonstnd lens
S0590	Misc integral lens serv
S0592	Comp cont lens eval
S0601	Screening proctoscopy
S0605	Digital rectal examination,
S0610	Annual gynecological examina
S0612	Annual gynecological examina
S0618	Audiometry for hearing aid
S0620	Routine ophthalmological exa
S0621	Routine ophthalmological exa
S0622	Phys exam for college
S0630	Removal of sutures
S0800	Laser in situ keratomileusis
S0810	Photorefractive keratectomy
S0812	Phototherap keratect
S0820	Computerized corneal topogra
S0830	Ultrasound pachymetry
S1001	Deluxe item
S1002	Custom item
S1015	IV tubing extension set
S1016	Non-pvc intravenous administ
S1025	Inhal nitric oxide neonate
S1030	Gluc monitor purchase
S1031	Gluc monitor rental
S1040	Cranial remold orth, rigid
S2053	Transplantation of small int
S2054	Transplantation of multivisc
S2055	Harvesting of donor multivis
S2060	Lobar lung transplantation
S2061	Donor lobectomy (lung)
S2065	Simult panc kidn trans
S2070	Cysto laser tx ureteral calc
S2080	Laup
S2082	Lap adjustable gastric band

HCPCS Code	Abbreviated Description
S2083	Adjustment gastric band
S2085	Laparoscop gastric bypass
S2090	Open cryosurg renal
S2091	Perc cryosurg renal
S2095	Transcath emboliz microspher
S2102	Islet cell tissue transplant
S2103	Adrenal tissue transplant
S2107	Adoptive immunotherapy
S2113	Arthro chondrocyte implant
S2115	Periacetabular osteotomy
S2120	Low density lipoprotein (LDL)
S2130	ERA of reflux saphenous vein
S2131	Laser ablat saphenous vein
S2135	Neurolysis interspace foot
S2140	Cord blood harvesting
S2142	Cord blood-derived stem-cell
S2150	BMT harv/transpl 28d pkg
S2152	Solid organ transpl pkg
S2202	Echosclerotherapy
S2205	Minimally invasive direct co
S2206	Minimally invasive direct co
S2207	Minimally invasive direct co
S2208	Minimally invasive direct co
S2209	Minimally invasive direct co
S2211	Transv carotid stent placemt
S2213	Implant gastric stim
S2225	Myringotomy laser-assist
S2230	Implant semi-imp hear
S2235	Implant auditory brain imp
S2250	Uterine artery emboliz
S2255	Hysterosc oviduct occlus
S2260	Induced abortion 17-24 weeks
S2262	Abortion for fetal ind, 25 wks or grtr
S2265	Abortion for fetal ind, 25 – 28 wks
S2266	Abortion for fetal ind, 29 – 31 wks
S2267	Abortion for fetal ind, 32 wks or grtr
S2300	Arthroscopy, shoulder, surgi
S2340	Chemodenervation of abductor
S2341	Chemodenerv adduct vocal
S2342	Nasal endoscop po debrid
S2350	Diskectomy, anterior, with d
S2351	Diskectomy, anterior, with d
S2360	Vertebroplast cerv 1st

HCPCS Code	Abbreviated Description
S2361	Vertebroplast cerv addl
S2362	Kyphoplasty, first vertebra
S2363	Kyphoplasty, each addl
S2370	Intradiscal electrothermal
S2371	Each additional interspace
S2400	Fetal surg congen hernia
S2401	Fetal surg urin trac obstr
S2402	Fetal surg cong cyst malf
S2403	Fetal surg pulmon sequest
S2404	Fetal surg myelomeningo
S2405	Fetal surg sacrococ teratoma
S2409	Fetal surg noc
S2411	Fetoscop laser ther TTTS
S3000	Bilat dil retinal exam
S3620	Newborn metabolic screening
S3625	Maternal triple screen test
S3630	Eosinophil blood count
S3645	HIV-1 antibody testing of or
S3650	Saliva test, hormone level;
S3652	Saliva test, hormone level;
S3655	Antisperm antibody test
S3701	NMP-22 assay
S3708	Gastrointestinal fat absorpt
S3818	BRCA1 gene anal
S3819	BRCA2 gene anal
S3820	Comp BRCA1/BRCA2
S3822	Sing mutation brst/ovar
S3823	3 mutation brst/ovar
S3828	Comp MLH1 gene
S3829	Comp MSH2 gene
S3830	Gene test HNPCC comp
S3831	Gene test HNPCC single
S3833	Comp APC sequence
S3834	Sing mutation APC
S3835	Gene test cystic fibrosis
S3837	Gene test hemochromato
S3840	DNA analysis RET-oncogene
S3841	Gene test retinoblastoma
S3842	Gene test Hippel-Lindau
S3843	DNA analysis Factor V
S3844	DNA analysis deafness
S3845	Gene test alpha-thalassemia
S3846	Gene test beta-thalassemia

HCPCS Code	Abbreviated Description
S3847	Gene test Tay-Sachs
S3848	Gene test Gaucher
S3849	Gene test Niemann-Pick
S3850	Gene test sickle cell
S3851	Gene test Canavan
S3852	DNA analysis APOE Alzheimer
S3853	Gene test myo musclr dyst
S3890	Fecal DNA analysis
S3900	Surface EMG
S3902	Ballistocardiogram
S3904	Masters two step
S4005	Interim labor facility global
S4011	IVF package
S4013	Compl gift case rate
S4014	Compl zift case rate
S4015	Complete IVF case rate
S4016	Frozen IVF case rate
S4017	INV canc a stim case rate
S4018	F EMB trns canc case rate
S4020	IVF canc a aspir case rate
S4021	IVF canc p aspir case rate
S4022	Asst oocyte fert case rate
S4023	Incompl donor egg case rate
S4025	Donor serv IVF case rate
S4026	Procure donor sperm
S4027	Store prev froz embryos
S4028	Microsurg epi sperm asp
S4030	Sperm procure init visit
S4031	Sperm procure subs visit
S4035	Stimulated iui case rate
S4036	Intravag cult case rate
S4037	Cryo embryo transf case rate
S4040	Monit store cryo embryo 30 d
S4981	Insert levonorgestrel ius
S4989	Contracept IUD
S4990	Nicotine patch legend
S4991	Nicotine patch nonlegend
S4993	Contraceptive pills for bc
S4995	Smoking cessation gum
S5000	Prescription drug, generic
S5001	Prescription drug,brand name
S5010	5% dextrose and 45% saline
S5011	5% dextrose in lactated ring

HCPCS Code	Abbreviated Description
S5012	5% dextrose with potassium
S5013	5% dextrose/45%saline,1000ml
S5014	5% dextrose/45%saline,1500ml
S5035	HIT routine device maint
S5036	HIT device repair
S5497	HIT cath care noc
S5498	HIT simple cath care
S5100	Adult daycare services 15 min
S5101	Adult day care per half day
S5102	Adult day care per diem
S5105	Centerbased daycare perdiem
S5108	Homecare train pt 15 min
S5109	Homecare train pt session
S5110	Family homecare training 15m
S5111	Family homecare train/sessio
S5115	Nonfamily homecare train/15m
S5116	Nonfamily HC train/session
S5120	Chore services per 15 min
S5121	Chore services per diem
S5125	Attendant care service /15m
S5126	Attendant care service /diem
S5130	Homaker service nos per 15m
S5131	Homemaker service nos /diem
S5135	Adult companioncare per 15m
S5136	Adult companioncare per diem
S5140	Adult foster care per diem
S5141	Adult foster care per month
S5145	Child fostercare th per diem
S5146	Ther fostercare child /month
S5150	Unskilled respite care /15m
S5151	Unskilled respitecare /diem
S5160	Emer response sys install&tst
S5161	Emer rspns sys serv permonth
S5162	Emer rspns system purchase
S5165	Home modifications per serv
S5170	Homedelivered prepared meal
S5175	Laundry serv,ext,prof,/order
S5180	HH respiratory thrpy in eval
S5181	HH respiratory thrpy nos/day
S5185	Med reminder serv per month
S5190	Wellness assessment by nonph
S5199	Personal care item nos each
S5501	HIT complex cath care

HCPCS Code	Abbreviated Description
S5502	HIT interim cath care
S5517	HIT declotting kit
S5518	HIT cath repair kit
S5520	HIT picc insert kit
S5521	HIT midline cath insert kit
S5522	HIT picc insert no supp
S5523	HIP midline cath insert kit
S5550	Insulin rapid 5 u
S5551	Insulin most rapid 5 u
S5552	Insulin intermed 5 u
S5553	Insulin long acting 5 u
S5560	Insulin reuse pen 1.5 ml
S5561	Insulin reuse pen 3 ml
S5565	Insulin cartridge 150 u
S5566	Insulin cartridge 300 u
S5570	Insulin dispos pen 1.5 ml
S5571	Insulin dispos pen 3 ml
S8004	Radioimmuno loc of trgtd cells
S8030	Tantalum ring application
S8035	Magnetic source imaging
S8037	mrcp
S8040	Topographic brain mapping
S8042	MRI low field
S8049	Intraoperative radiation the
S8055	Us guidance fetal reduct
S8075	CAD of digital mammogr
S8080	Scintimammography
S8085	Fluorine-18 fluorodeoxygluco
S8092	Electron beam computed tomog
S8095	Wig (for medically-induced h
S8096	Portable peak flow meter
S8097	Asthma kit
S8100	Spacer without mask
S8101	Spacer with mask
S8110	Peak expiratory flow rate (p
S8120	O2 contents gas cubic ft
S8121	O2 contents liquid lb
S8182	Humidifier non-servo
S8183	Humidifier dual servo
S8185	Flutter device
S8186	Swivel adaptor
S8189	Trach supply noc
S8190	Electronic spirometer

HCPCS Code	Abbreviated Description
S8210	Mucus trap
S8260	Oral orthotic for treatment
S8262	Mandib ortho repos device
S8265	Haberman feeder
S8415	Supplies for home delivery
S8450	Splint digit
S8451	Splint wrist or ankle
S8452	Splint elbow
S8460	Camisole post-mast
S8490	100 insulin syringes
S8948	Low-level laser trmt 15 min
S8950	Complex lymphedema therapy,
S8990	PT or manip for maint
S8999	Resuscitation bag
S9001	Home uterine monitor with or
S9007	Ultrafiltration monitor
S9015	Automated EEG monitoring
S9022	Digital subtraction angiogra
S9024	Paranasal sinus ultrasound
S9025	Omnicardiogram/cardiointegra
S9034	ESWL for gallstones
S9055	Procuren or other growth fac
S9056	Coma stimulation per diem
S9061	Medical supplies and equipme
S9075	Smoking cessation treatment
S9083	Urgent care center global
S9088	Services provided in urgent
S9090	Vertebral axial decompressio
S9092	Canolith repositioning
S9098	Home phototherapy visit
S9109	CHF telemonitoring month
S9117	Back school visit
S9122	Home health aide or certifie
S9123	Nursing care, in the home; b
S9125	Respite care, in the home, p
S9127	Social work visit, in the ho
S9128	Speech therapy, in the home,
S9129	Occupational therapy, in the
S9131	PT in the home per diem
S9140	Diabetic Management Program,
S9141	Diabetic Management Program,
S9145	Insulin pump initiation
S9150	Evaluation by Ocularist

HCPCS Code	Abbreviated Description
S9208	Home mgmt preterm labor
S9209	Home mgmt PPROM
S9211	Home mgmt gest hypertension
S9212	Hm postpar hyper per diem
S9213	Hm preeclamp per diem
S9214	Hm gest dm per diem
S9325	HIT pain mgmt per diem
S9326	HIT cont pain per diem
S9327	HIT int pain per diem
S9328	HIT pain imp pump diem
S9329	HIT chemo per diem
S9330	HIT cont chem diem
S9331	HIT intermit chemo diem
S9335	HT hemodialysis diem
S9336	HIT cont anticoag diem
S9338	HIT immunotherapy diem
S9339	HIT periton dialysis diem
S9340	HIT enteral per diem
S9341	HIT enteral grav diem
S9342	HIT enteral pump diem
S9343	HIT enteral bolus nurs
S9345	HIT anti-hemophil diem
S9346	HIT alpha-1-proteinas diem
S9347	HIT longterm infusion diem
S9348	HIT sympathomim diem
S9349	HIT tocolysis diem
S9351	HIT cont antiemetic diem
S9353	HIT cont insulin diem
S9355	HIT chelation diem
S9357	HIT enzyme replace diem
S9359	HIT anti-tnf per diem
S9361	HIT diuretic infus diem
S9363	HIT anti-spasmotic diem
S9364	HIT tpn total diem
S9365	HIT tpn 1 liter diem
S9366	HIT tpn 2 liter diem
S9367	HIT tpn 3 liter diem
S9368	HIT tpn over 3l diem
S9370	HT inj antiemetic diem
S9372	HT inj anticoag diem
S9373	HIT hydra total diem
S9374	HIT hydra 1 liter diem
S9375	HIT hydra 2 liter diem

HCPCS Code	Abbreviated Description
S9376	HIT hydra 3 liter diem
S9377	HIT hydra over 3l diem
S9379	HIT noc per diem
S9381	HIT high risk/escort
S9401	Anticoag clinic per session
S9430	Pharmacy comp/disp serv
S9434	Mod solid food suppl
S9435	Medical foods for inborn err
S9436	Lamaze class
S9437	Childbirth refresher class
S9438	Cesarean birth class
S9439	VBAC class
S9441	Asthma education
S9442	Birthing class
S9443	Lactation class
S9444	Parenting class
S9446	PT education noc group
S9447	Infant safety class
S9449	Weight mgt class
S9451	Exercise class
S9452	Nutrition class
S9453	Smoking cessation class
S9454	Stress mgmt class
S9455	Diabetic Management Program,
S9460	Diabetic Management Program,
S9465	Diabetic Management Program,
S9470	Nutritional counseling, diet
S9472	Cardiac rehabilitation progr
S9473	Pulmonary rehabilitation pro
S9474	Enterostomal therapy by a re
S9475	Ambulatory setting substance
S9476	Vestibular rehab per diem
S9480	Intensive outpatient psychia
S9484	Crisis intervention per hour
S9485	Crisis intervention mental h
S9490	HIT corticosteroid diem
S9494	HIT antibiotic total diem
S9497	HIT antibiotic q3h diem
S9500	HIT antibiotic q24h diem
S9501	HIT antibiotic q12h diem
S9502	HIT antibiotic q8h diem
S9503	HIT antibiotic q6h diem
S9504	HIT antibiotic q4h diem

HCPCS Code	Abbreviated Description
S9529	Venipuncture home/snf
S9537	HT hem horm inj diem
S9538	HIT blood products diem
S9542	HT inj noc per diem
S9558	HT inj growth horm diem
S9559	HIT inj interferon diem
S9560	HT inj hormone diem
S9562	Palivizumab home inj perdiem
S9590	In home irrigation therapy
S9802	Specialty drug admin/nsg srv
S9803	Each additional hour
S9810	HT pharm per hour
S9900	Christian sci pract visit
S9970	Health club membership yr
S9975	Transplant related per diem
S9976	Lodging per diem
S9977	Meals per diem
S9981	Med record copy admin
S9986	Not medically necessary svc
S9988	Serv part of phase I trial
S9989	Services outside US
S9990	Services provided as part of
S9991	Services provided as part of
S9992	Transportation costs to and
S9994	Lodging costs (e.g. hotel ch
S9996	Meals for clinical trial par
S9999	Sales tax
T1000	Priv duty/inde nurse, to 15 mi
T1001	Nursing assessement/eval
T1002	RN services, up to 15 min
T1003	LPN/LVN serv, up to 15 min
T1004	Nurs aide serv, up to 15 min
T1005	Respite care, up to 15 min
T1006	Family/couple counseling
T1007	Treatment plan development
T1009	Child sitting services
T1010	Meals when receive services
T1012	Alcohol/subs abs, skills dev
T1013	Sign lang or oral intrpr serv
T1014	Telehealth transmit, per min
T1016	Case management
T1017	Targeted case management
T1018	School-based IEP ser bundled

HCPCS Code	Abbreviated Description
T1019	Personal care ser per 15 min
T1020	Personal care ser per diem
T1021	HH aide or CN aide per visit
T1022	Contracted services per day
T1023	Program intake assessment
T1024	Team evaluation & management
T1025	Ped compr care pkg, per diem
T1026	Ped compr care pkg, per hour
T1027	Family training & counseling
T1028	Home environment assessment
T1029	Dwelling lead investigation
T1030	RN home care per diem
T1031	LPN home care per diem
T1502	Medication admin visit
T1999	NOC retail items andsupplies
T2001	N-et; patient attend/escort
T2002	N-et; per diem
T2003	N-et; encounter/trip
T2004	N-et; commerc carrier, pass
T2005	N-et; stretcher van
T2006	Amb response & trt, no trans
T2007	Non-emer transport wait time
T2010	PASRR LEVEL I
T2011	PASRR LEVEL II
T2012	Habil ed waiver, per diem
T2013	Habil ed waiver per hour
T2014	Habil prevoc waiver, per d
T2015	Habil prevoc waiver per hr
T2016	Habil res waiver per diem
T2017	Habil res waiver 15 min
T2018	Habil sup empl waiver/diem
T2019	Habil sup empl waiver 15min
T2020	Day habil waiver per diem
T2021	Day habil waiver per 15 min
T2022	Case management, per month
T2023	Targeted case mgmt per month
T2024	Serv asmnt/care plan waiver
T2025	Waiver service, nos
T2026	Special childcare waiver/d
T2027	Spec childcare waiver 15 min
T2028	Special supply, nos waiver
T2029	Special med equip, noswaiver
T2030	Assist living waiver/month

HCPCS Code	Abbreviated Description
T2031	Assist living waiver/diem
T2032	Res care, nos waiver/month
T2033	Res, nos waiver per diem
T2034	Crisis interven waiver/diem
T2035	Utility services waiver
T2036	Camp overnite waiver/session
T2037	Camp day waiver/session
T2038	Comm trans waiver/service
T2039	Vehicle mod waiver/service
T2040	Financial mgt waiver/15min
T2041	Support broker waiver/15 min
T2042	Hospice routine home care
T2043	Hospice continuous home care
T2044	Hospice respite care
T2045	Hospice general care
T2046	Hospice long term care, r&b
T2048	Bh ltc res r&b, per diem
T2101	Breast milk proc/store/dist
T5001	Special position seat/vehicl
T5999	Supply, nos
V5095	Implant mid ear hearing pros
V5110	Hearing aid dispensing fee

HCPCS Code	Abbreviated Description
V5254	Hearing aid, digit, mon, cic
V5255	Hearing aid, digit, mon, itc
V5256	Hearing aid, digit, mon, ite
V5257	Hearing aid, digit, mon, bte
V5258	Hearing aid, digit, mon, cic
V5259	Hearing aid, digit, mon, itc
V5260	Hearing aid, digit, mon, ite
V5261	Hearing aid, digit, mon, bte
V5262	Hearing aid, disp, monaural
V5263	Hearing aid, disp, binaural
V5265	Ear mold/insert, disp
V5268	ALD Telephone Amplifier
V5269	Alerting device, any type
V5270	ALD, TV amplifier, any type
V5271	ALD, TV caption decoder
V5272	Tdd
V5273	ALD for cochlear implant
V5274	ALD unspecified
V5275	Ear impression
V5298	Hearing aid noc
V5299	Hearing service

NON-COVERED MODIFIERS

All five-digit CPT® modifiers (e.g. 09951)

-AJ Clinical Social Worker

-SU Procedure Performed in Physician's Office (to denote use of facility and equipment)

APPENDIX E
MODIFIERS THAT AFFECT PAYMENT

Only modifiers that affect payment are listed in this section. Refer to current CPT® and HCPCS books for complete modifier descriptions and instructions.

CPT® MODIFIERS

-22 Unusual services
Procedures with this modifier may be individually reviewed prior to payment. A report is required for this review. Payment varies based on the report submitted.

-24 Unrelated evaluation and management (E/M) services by the same physician during a postoperative period
Used to indicate an evaluation and management service unrelated to the surgical procedure was performed during a postoperative period. *Documentation must be submitted with the billing form when this modifier is used.* Payment is made at one hundred percent of the fee schedule level or billed charge, whichever is less.

-25 Significant, separately identifiable evaluation and management (E/M) service by the same physician on the day of a procedure
Payment is made at one hundred percent of the fee schedule level or billed charge, whichever is less. Refer to the Professional Services section for information on the use of modifier –25.

-26 Professional component
Certain procedures are a combination of the professional (-26) and technical (-TC) components. This modifier should be used when only the professional component is performed. When a global service is performed, neither the -26 nor the -TC modifier should be used.

-50 Bilateral surgery
The bilateral modifier identifies cases where a procedure typically performed on one side of the body is, in fact, performed on both sides of the body. Payment is made at one hundred fifty percent of the global surgery fee for the procedure. Providers must bill using two line items on the bill form. The modifier -50 should be applied to the second line item.

-51 Multiple surgery
For procedure codes that represent multiple surgical procedures, payment is made based on the fee schedule allowance associated with that code. Refer to the global surgery rules for additional information.

-52 Reduced services
Payment is made at the fee schedule level or billed charge, whichever is less.

-53 Discontinued services
CMS has established reduced RVUs for CPT® code 45378 when billed with modifier -53. The department prices this code-modifier combination according to those RVUs.

-54 Surgical care only (1)
When one physician performs a surgical procedure and another provides preoperative and/or postoperative management.

-55 Postoperative management only (1)
When one physician performs the postoperative management and another physician has performed the surgical procedure.

-56 Preoperative management only (1)
When one physician performs the preoperative care and evaluation and another physician performs the surgical procedure.

(1) **When providing less than the global surgical package providers should use modifiers -54, -55, and -56.** These modifiers are designed to ensure that the sum of all allowances for all providers does not exceed the total allowance for the global surgery period. These modifiers allow direct payment to the provider of each portion of the global surgery services.

-57 Decision for surgery
Used only when the decision for surgery was made during the preoperative period of a surgical procedure with a global surgery follow-up period. It should not be used with visits furnished during the global period of minor procedures (0-10 day global period) unless the purpose of the visit is a decision for major surgery. Separate payment should be made even if the visit falls within the global surgery period. No separate documentation is needed when submitting a billing form with this modifier.

-60 Altered Surgical Field
Procedures with this modifier may be individually reviewed prior to payment. A report is required for this review. Payment varies based on the report submitted.

-62 Two surgeons
For surgery requiring the skills of two surgeons (usually with a different specialty), each surgeon is paid at 62.5% of the global surgical fee. No payment is made for an assistant-at-surgery in these cases.

-66 Team surgery
Used when highly complex procedures are carried out by a surgical team. This may include the concomitant services of several physicians, often of different specialties, other highly skilled, specially trained personnel, and various types of complex equipment. Procedures with this modifier are reviewed and priced on an individual basis. Supporting documentation is required for this review.

-78 Return to the operating room for a related procedure during the postoperative period
Payment is made at one hundred percent of the fee schedule level or billed amount, whichever is less.

-79 Unrelated procedure or service by the same physician during the postoperative period
Use of this modifier allows separate payment for procedures not associated with the original surgery. Payment is made at one hundred percent of the fee schedule level or billed amount, whichever is less.

-80 Assistant surgeon [(2)]

-81 Minimum assistant surgeon [(2)]

-82 Assistant surgeon (when qualified resident surgeon not available) [(2)]

(2) **Assistant Surgeon Modifiers**. Physicians who assist the primary physician in surgery should use modifiers -80, -81 or -82 depending on the medical necessity. Payment for procedures with these modifiers is made at the billed charge or twenty percent of the global surgery amount for the procedure, whichever is less. Refer to the assistant surgeon indicator in the Professional Services Fee Schedule to determine if assistant surgeon fees are payable.

-91 Repeat clinical diagnostic laboratory test performed on the same day to obtain subsequent reportable test values(s) (separate specimens taken in separate encounters)

Payment will be made for repeat test(s) performed for the same patient on the same day when specimen(s) have been taken from separate encounters. Test(s) normally performed as a series, e.g. glucose tolerance test do not qualify as separate encounters. The medical necessity for repeating the test(s) must be documented in the patient record.

-99 Multiple modifiers

This modifier should only be used when two or more modifiers affect payment.
Payment is based on the policy associated with each individual modifier that describes the services performed. For billing purposes, only modifier -99 should go in the modifier column, with the individual descriptive modifiers that affect payment listed elsewhere on the billing form.

HCPCS MODIFIERS

-GT Teleconsultations via interactive audio and video telecommunication systems

Payment policies for teleconsultations are located in the Professional Services section.

-LT Left side

Although this modifier does not affect payment, it should be used when billing for bilateral services. This will help reduce duplicate bills and minimize payment delays.

-RT Right side

Although this modifier does not affect payment, it should be used when billing for bilateral services. This will help reduce duplicate bills and minimize payment delays.

-SG Ambulatory surgical center (ASC) facility service

Bill the appropriate CPT® surgical code(s) adding this modifier -SG to each surgery code.

-TC Technical component

Certain procedures are a combination of the professional (-26) and technical (-TC) components. This modifier should be used when only the technical component is performed. When a global service is performed, neither the -26 nor -TC modifier should be used. Refer to the CPT® modifier section for the use of the -26 modifier.

LOCAL MODIFIER

-1S Surgical dressings for home use
Bill the appropriate HCPCS code for each dressing item using this modifier -1S for each item. Use this modifier to bill for surgical dressing supplies dispensed for home use.

APPENDIX F
ANESTHESIA SERVICES PAID WITH RBRVS

Do not rely solely on the descriptions given in the appendices for complete coding information. Refer to a current CPT® or HCPCS book for complete coding information.

PAIN MANAGEMENT AND NERVE BLOCK CODES

CPT® Code	Abbreviated Description
01996	Manage daily drug therapy
20526	Ther injection, carpal tunnel
20550	Inject tendon/ligament/cyst
20551	Inject tendon origin/insert
20552	Inject trigger point, 1 or 2
20553	Inject trigger points, >3
20600	Drain/inject, joint/bursa
20605	Drain/inject, joint/bursa
20610	Drain/inject, joint/bursa
20612	Aspiration and/or inj of ganglion
27096	Inject sacroiliac joint
61790	Treat trigeminal nerve
62263	Lysis epidural adhesions
62264	Perc lysis of epidural adhesions
62270	Spinal fluid tap, diagnostic
62272	Drain spinal fluid
62273	Treat epidural spine lesion
62281	Treat spinal cord lesion
62282	Treat spinal canal lesion
62284	Injection for myelogram
62290	Inject for spine disk x-ray
62291	Inject for spine disk x-ray
62310	Inject spine c/t
62311	Inject spine l/s (cd)
62318	Inject spine w/cath, c/t
62319	Inject spine w/cath l/s (cd)
64400	Injection for nerve block
64402	Injection for nerve block
64405	Injection for nerve block
64408	Injection for nerve block
64410	Injection for nerve block
64412	Injection for nerve block
64413	Injection for nerve block
64415	Injection for nerve block
64416	Inj anesth agent; brachial plexus

CPT® Code	Abbreviated Description
64417	Injection for nerve block
64418	Injection for nerve block
64420	Injection for nerve block
64421	Injection for nerve block
64425	Injection for nerve block
64430	Injection for nerve block
64435	Injection for nerve block
64445	Injection for nerve block
64446	Inj anesth agent; sciatic nerve
64447	Inj anesth agent; femoral nerve
64448	Inj anesth agent; femoral nerve
64449	Inj anesth agent; lumbar plexus
64450	Injection for nerve block
64470	Inj paravertebral c/t
64472	Inj paravertebral c/t add-on
64475	Inj paravertebral l/s
64476	Inj paravertebral l/s add-on
64479	Inj foramen epidural c/t
64480	Inj foramen epidural add-on
64483	Inj foramen epidural l/s
64484	Inj foramen epidural add-on
64505	Injection for nerve block
64508	Injection for nerve block
64510	Injection for nerve block
64517	Injection for nerve block
64520	Injection for nerve block
64530	Injection for nerve block
64550	Apply neurostimulator
64553	Implant neuroelectrodes
64555	Implant neuroelectrodes
64560	Implant neuroelectrodes
64565	Implant neuroelectrodes
64573	Implant neuroelectrodes
64575	Implant neuroelectrodes
64577	Implant neuroelectrodes

CPT® Code	Abbreviated Description
64580	Implant neuroelectrodes
64585	Revise/remove neuroelectrode
64590	Implant neuroreceiver
64595	Revise/remove neuroreceiver
64600	Injection treatment of nerve
64605	Injection treatment of nerve
64610	Injection treatment of nerve
64612	Destroy nerve, face muscle
64613	Destroy nerve, spine muscle
64620	Injection treatment of nerve
64622	Destr paravertebrl nerve l/s

CPT® Code	Abbreviated Description
64623	Destr paravertebral n add-on
64626	Destr paravertebri nerve c/t
64627	Destr paravertebral n add-on
64630	Injection treatment of nerve
64640	Injection treatment of nerve
64680	Injection treatment of nerve
64681	Injection treatment of nerve
64802	Remove sympathetic nerves
64804	Remove sympathetic nerves
64809	Remove sympathetic nerves
64818	Remove sympathetic nerves

OTHER ACCEPTED CODES

CPT® Code	Abbreviated Description
31500	Insert emergency airway
36425	Establish access to vein
36489	Insertion of catheter, vein
36491	Insertion of catheter, vein
36600	Withdrawal of arterial blood
36620	Insertion catheter, artery
36625	Insertion catheter, artery
63600	Remove spinal cord lesion
76000	Fluoroscope examination
76003	Fluoroscope exam, extensive
76005	Fluoroguide for spine inject
76496	Unlisted fluoroscopic proc
93503	Insert/place heart catheter

APPENDIX G
OUTPATIENT DRUG FORMULARY

The following is a list of drugs and therapeutic classes (or class codes) and their status on L&I's outpatient formulary. The formulary may change from time to time to reflect the Pharmacy and Therapeutic (P&T) Committee's recommendations or administrative changes.

PLEASE NOTE:

- This is an outpatient drug formulary. Many of the drugs not included on the formulary may be appropriate in other settings, such as inpatient, outpatient surgery, emergency room, and clinics or offices, and are covered when billed appropriately.
- Drugs or therapeutic classes listed on the formulary do not guarantee coverage and maybe subject to the department's policy and appropriateness for the accepted conditions.
- Status of the therapeutic classes depends on the drugs' approved indication and is as followed:
    - A = Allowed
    - PA = Prior Authorization required
    - D = Denied

The first drug classes listed are part of the Washington State's evidence-based Preferred Drug List (PDL) and will be subject to the endorsing practioner therapeutic interchange program (TIP)

State Preferred Drug List

Status	TCC	Therapeutic Class Description	Preferred Drug(s)
A	D4K	Gastric Acid Secretion Reducer	
		Proton Pump Inhibitors	Omeprazole (OTC)
A	H3A	Analgesics, Narcotics	
		Long Acting Opioids	Methadone Morphine, Long-Acting
A	H6H	Skeletal Muscle Relaxants	Baclofen Chlorzoxazone Cyclobenzaprine Methocarbamol
A	R1A	Urinary Tract Antispasmodic Agents	Oxybutynin Chloride
A	S2B	NSAIDs, Cyclooxygenase Inhibitor Type	Diclofenac Potassium Diclofenac Sodium Etodolac Fenoprofen Calcium Flurbiprofen Ibuprofen Indomethacin Ketoprofen Ketorolac Tromethamine Meclofenamate Sodium Nabumetone Naproxen Piroxicam Oxaprozin Sulindac Tolmetin Sodium

Compound Drugs

Status	TCC	Therapeutic Class Description	Preferred Drug(s)
PA	000	Compound Drugs	None

Cardiovascular System

Status	GC3	Therapeutic Class Description	Preferred Drug(s)
PA	A1A	Digitalis Glycosides	None
A	A1B	Xanthines	Aerolate SR Alertness Aminophylline Stay Awake Theophylline Theophylline Tab SA T-Phyl
D	A1C	Inotropic Drugs	None
A	A1D	General Bronchodilator Agents	Ipratropium Bromide
PA	A2A	Antiarrhythmics	None
PA	A4A	Hypotensives-Vasodilators	None
PA	A4B	Hypotensives-Sympatholytic	None
PA	A4D	Hypotensives-Angiotensin Converting Enzyme Blockers	None
PA	A4F	Hypotensives, Angiotensin Receptor Antagonist	None
PA	A4K	ACE Inhibitor/Calcium Channel Blocker Combination	None
PA	A4Y	Hypotensives-Miscellaneous	None
D	A6U	Cardiovascular Diagnostics	None
D	A6V	Cardiovascular Diagnostics – Non Radiopaque	None
PA	A7B	Coronary Vasodilators	None
PA	A7C	Peripheral Vasodilators	None
PA	A7E	Vasodilators-Miscellaneous	None
D	A8O	Venosclerosing Agents	None
PA	A9A	Calcium Channel Blocking Agents	None

Respiratory System

Status	GC3	Description	Preferred Drug(s)
A	B0A	Miscellaneous Respiratory Inhalants	Sodium Chloride Broncho Saline Saline
D	B1A	Lung Surfactants	None
D	B1B	Pulm Antihypertensive, Endothelin Receptor Antagonist-Type	None
PA	B1C	Pulmonary Antihypertensives, Prostaglandin Type	None
A	B3A	Mucolytics	Acetylcysteine
A	B3J	Expectorants	Benylin Guaifenesin Guaifenesin W/Codeine Guaifenesin W/Dextromethorphan Guaifenesin W/Pseudoephedrine Hydrocodone W/Guaifenesin

Status	GC3	Description	Preferred Drug(s)
A	B3K	Cough And Cold Preparations	Advil Cold & Sinus Carbinoxamine Compound Promethazine W/Codeine

Electrolyte Balancing Sys/Metabolic Sys/Nutrition

Status	GC3	Description	Preferred Drug(s)
A	C0B	Water	All
D	C0C	Drugs Used To Treat Acidosis	None
PA	C0D	Antialcoholic Preparations	None
PA	C0K	Bicarbonate Producing/Containing Agents	None
PA	C1A	Electrolyte Depleters	None
PA	C1B	Sodium Replacement	None
PA	C1D	Potassium Replacement	None
PA	C1F	Calcium Replacement	None
PA	C1H	Magnesium Replacement	None
D	C1K	Cardioplegic Solutions	None
PA	C1P	Phosphate Replacement	None
PA	C1W	Electrolyte Replacement	None
D	C2H	Respiratory Gases	None
PA	C3B	Iron Replacement	None
PA	C3C	Zinc Replacement	None
PA	C3H	Iodine Replacement	None
PA	C3M	Miscellaneous Mineral Replacement	None
PA	C4G	Insulins	None
PA	C4K	Hypoglycemics, Insulin-Release Stim. Type	None
PA	C4L	Hypoglycemics, Biguanide Type (N-S)	None
PA	C4M	Hypoglycemics, Alpha-Glucosidase Inhibitor Type (N-S)	None
PA	C4N	Hypoglycemics, Insulin-Response Enhancer (N-S)	None
PA	C4Q	Hypoglycemics, Combination	None
PA	C5A	Carbohydrates	None
PA	C5B	Protein Replacement	None
D	C5C	Infant Formulas	None
D	C5D	Diet Foods	None
D	C5F	Miscellaneous Food Supplements	None
D	C5G	Food Oils	None
A	C5J	IV Solutions: Dextrose/Water	All
A	C5K	IV Solutions: Dextrose/Saline	All
A	C5L	IV Solutions: Dextrose/Ringers	All
A	C5M	IV Solutions: Dextrose/Lactated Ringers	All
A	C5O	Solutions, Miscellaneous	All
D	C5U	Nutritional Therapy, Glucose Intolerance	None
D	C6A	Vitamin A Preparations	None
D	C6B	Vitamin B Preparations	None
PA	C6C	Vitamin C Preparations	None
D	C6D	Vitamin D Preparations	None
D	C6E	Vitamin E Preparations	None
D	C6F	Prenatal Vitamin Preparations	None
D	C6G	Geriatric Vitamin Preparations	None
D	C6H	Pediatric Vitamin Preparations	None

Status	GC3	Description	Preferred Drug(s)
D	C6I	Antioxidant Multivitamin Combinations	None
D	C6J	Bioflavonoids	None
PA	C6K	Vitamin K Preparations	None
PA	C6L	Vitamin B12 Preparations	None
PA	C6M	Folic Acid Preparations	None
D	C6N	Niacin Preparations	None
D	C6P	Panthenol Preparations	None
D	C6Q	Vitamin B6 Preparations	None
D	C6R	Vitamin B2 Preparations	None
D	C6T	Vitamin B1 Preparations	None
D	C6Z	Miscellaneous Multivitamin Preparations	None
D	C7A	Purine Inhibitors	None
D	C7D	Metabolic Deficiency Agents	None
A	C8A	Metallic Poison Antidotes	All
A	C8B	Acid And Alkali Poison Antidotes	All
A	C8E	Miscellaneous Antidotes	All

Biliary System/Gastro-Intestinal System

Status	GC3	Therapeutic Class Description	Preferred Drug(s)
D	D0U	Gastrointestinal Radiopaque Diagnostics	None
D	D1D	Dental Supplies	None
D	D2A	Fluoride Preparations	None
D	D2D	Tooth Ache Preparations	None
A	D4A	Acid Replacement	All
A	D4B	Antacids	Sodium Bicarbonate Alamag Aluminum Hydroxide Antacid W/Simethicone Calcium Carbonate
A	D4D	Antidiarrheal Microorganisms Agents	All
A	D4E	Antiulcer Preparations	Misoprostol Sucralfate
D	D4F	Antiulcer -- H. Pylori Agents	None
A	D4G	Gastric Enzymes	Lactaid Ultra
A	D4H	Oral Mucositis/Stomatitis Agents	All
A	D4I	Oral Mucositis/Stomatitis Antiinflammatory Agents	All
A	D4K	Gastric Acid Secretion Reducer	
		Histamine H2 Inhibitors	Cimetidine Famotidine Nizatidine Ranitidine
A	D4N	Antiflatulents	All
D	D4O	Gastrointestinal Ultrasnd Image Enhancing Adjnct, Diag	None
A	D4Q	Digestive Agents, Other	All
A	D5P	Intestinal Adsorbents And Protectives	All
PA	D6A	Drugs To Treat Chronic Inflammatory Diseases Of The Colon	None
D	D6C	Irritable Bowel Syndrome Agent, 5HT-3 Antagonist-Type	None
A	D6D	Antidiarrheals	All

Status	GC3	Therapeutic Class Description	Preferred Drug(s)
D	D6E	Irritable Bowel Syndrome Agents, 5HT-4 Partial Agonist	None
PA	D6F	Drugs To Treat Chronic Inflammatory Colon Dx 5 – Aminosalicyl	None
A	D6H	Hemorrhoidal Agents	All
A	D6S	Laxatives And Cathartics	All
A	D7A	Bile Salts	All
A	D7B	Choleretics	All
D	D7C	Hepatic Diagnostics	None
D	D7D	Drugs To Treat Hereditary Tyrosinemia	None
PA	D7J	Hepatic Dysfunction Preventive/ Therapy Agents	None
A	D7L	Bile Salt Inhibitors	Cholestyramine Cholestyramine Light Colestid Locholest Locholest Light Prevalite Welchol
D	D7T	Biliary Diagnostics	None
D	D7U	Biliary Diagnostics, Radiopaque	None
A	D8A	Pancreatic Enzymes	Cotazym Creon 10 Creon 20 Creon 5 Pancrelipase
A	D9A	Ammonia Inhibitors	Lactulose

Male Genital System

Status	GC3	Therapeutic Class Description	Preferred Drug(s)
PA	F1A	Androgenic Agents	None
PA	F2A	Drugs To Treat Impotency	None

Female Genital System

Status	GC3	Therapeutic Class Description	Preferred Drug(s)
D	G0U	Uterine Radiopaque Diagnostic Agents	None
D	G1A	Estrogenic Agents	None
D	G1B	Estrogen/Androgen Combination Preparations	None
D	G2A	Progestational Agents	None
D	G3A	Oxytocics	None
D	G8A	Contraceptives, Oral	None
D	G8B	Contraceptives, Implantable	None
D	G8C	Contraceptives, Injectable	None
PA	G8D	Abortifacient, Progesterone Receptor Antagonist Type	None
D	G8F	Contraceptives, Transdermal	None
D	G9A	Contraceptives, Intravaginal	None
D	G9B	Contraceptives, Intravaginal, Systemic	None

Nervous System (Except Autonomic)

Status	GC3	Therapeutic Class Description	Preferred Drug(s)
A	H0A	Local Anesthetics	Cepacol
D	H0E	Agents To Treat Multiple Sclerosis	None
D	H1A	Alzheimer's Tx, N-Methyl-D-Aspart (NMDA) Recept Antags	None
D	H1U	Cerebral Spinal Radiopaque Diagnostics	None
PA	H2A	Central Nervous System Stimulants	None
D	H2B	General Anesthetics, Inhalant	None
D	H2C	General Anesthetics, Injectable	None
A	H2D	Barbiturates (Phenobarbital Only)	Phenobarbital
A	H2E	Non-Barbiturate, Sedative-Hypnotics	Ambien Chloral Hydrate Estazolam Diphenhydramine Flurazepam Sonata Temazepam Triazolam
A	H2F	Antianxiety Drugs	Alprazolam Buspirone Chlordiazepoxide Clorazepate Dipotassium Diazepam Lorazepam Oxazepam
A	H2G	Anti-Psychotics, Phenothiazines	Chlorpromazine Fluphenazine Perphenazine Thioridazine Trifluoperazinel
A	H2M	Anti-Mania Drugs	Eskalith CR Lithium Carbonate Lithium Citrate
A	H2S	Serotonin Specific Reuptake Inhibitor (SSRI's)	Celexa Fluoxetine Fluvoxamine Maleate Lexapro Paroxetine Paxil Sarafem Zoloft
D	H2T	Alcohol-Systemic Use	None
A	H2U	Tricyclic Antidepressants & Related Non-SRI	Amitriptyline Desipramine Doxepin Imipramine Maprotiline Nortriptyline
PA	H2V	Anti-Narcolepsy/Anti-Hyperkinesis Agents	None
A	H2W	Tricyclic Antidepressant/Phenothiazine Combinations	Amitriptyline W/Perphenazine

Status	GC3	Therapeutic Class Description	Preferred Drug(s)
A	H2X	Tricyclic Antidepressant/Benzodiazepine Combination	Amitriptyline W/Chlordiazepoxide
A	H3A	Analgesics, Narcotics	
		Short Acting Opioids	Acetaminophen W/Codeine Aspirin W/Codeine Butalbital Compound W/Codeine Codeine Phosphate Codeine Sulfate Hydrocodone W/Acetaminophen Hydromorphone Meperidine Morphine Sulfate Oxycodone Oxycodone W/Acetaminophen Oxycodone W/Aspirin Propoxyphene Propoxyphene W/Acetaminophen Propoxyphene Napsylate W/Acetaminophen RMS-Suppository Pentazocine W/Naloxone Pentazocine W/Acetaminophen Tramadol
A	H3C	Analgesics, Non-Narcotics	Duraclon
A	H3D	Salicylate Analgesics	Ascriptin Aspirin Aspirin Buffered Butalbital Compound Choline Mag Trisalicylate Diflunisal Salsalate
A	H3E	Analgesic/Antipyretics, Non-Salicylate	Tylenol Acetaminophen/Caff/Butalb Percogesic
PA	H3F	Antimigraine Preparations	None
D	H3H	Analgesics Narcotic, Anesthetic Adjunct	None
A	H3T	Narcotic Antagonists	Naloxone
A	H4B	Anticonvulsants	Carbamazepine Clonazepam Depakote Diastat Dilantin Lamictal Mebaral Neurontin Phenytoin Sodium, Extended Primidone Tegretol XR Topamax Trileptal Valproic Acid Zonegran
PA	H6A	Antiparkinsonism Drugs, Other	None
A	H6B	Antiparkinsonism Drugs, Anticholinergic	Benztropine Mesylate Trihexyphenidyl

Status	GC3	Therapeutic Class Description	Preferred Drug(s)
A	H6C	Antitussive, Non-Narcotic	Benzonatate Tussin
A	H6E	Emetics	Ipecac
A	H6J	Anti-Emetics	Dimenhydrinate Emetrol Kytril Meclizine Prochlorperazine Promethazine Torecan Trimethobenzamide Zofran
A	H7B	Alpha-2 Receptor Antagonists	Remeron Soltab Mirtazapine
A	H7C	Serotonin-Norepinephrine Reuptake Inhib (SNRIs)	Effexor
PA	H7D	Norepinephrine And Dopamine Reuptake Inhib (NDRIs)	None
A	H7E	Serotonin-2 Antagonist/Reuptake Inhib (SARIs)	Trazodone
A	H7J	MAOIs - Non-Selective & Irreversible	All
A	H7O	Antipsychotic, Dopamine Antagonist, Butyrophenones	All
A	H7P	Antipsychotic, Dopamine Antagonist, Thioxanthenes	Thiothixene
A	H7R	Antipsychotic, Dopamine Antagonist, Diphenylbutylpiperidines	Orap
A	H7S	Antipsychotic, Dopamine And Serotonin Antagonist	Moban
A	H7T	Antipsychotic, Atypical Dopamine And Serotonin	Clozapine Risperdal Seroquel Zyprexa
A	H7U	Antipsychotic, Dopamine And Serotonin Antagonist	Loxapine Succinate
D	H7W	Anti-Narcolepsy/Anti-Cataplexy, Sedative-Type Agent	None
A	H7X	Antipsychotics, Atypical, D2 Partial Agonist/5HT Mixed	Abilify
PA	H7Y	Tx For Attn Deficit-Hyperactivity Disorder (ADHD), NRI-Type	None
A	H7Z	SSRI & Antipsych, Atyp, Dopamine & Serotonin Antagonist Combination	None

Autonomic Nervous System

Status	GC3	Therapeutic Class Description	Preferred Drug(s)
A	J1A	Parasympathetic Agents	Bethanechol Chloride
PA	J1B	Cholinesterase Inhibitors	None
A	J2A	Belladonna Alkaloids	Atropine Sulfate Belladonna W/Phenobarbital Hyoscyamine

Status	GC3	Therapeutic Class Description	Preferred Drug(s)
A	J2B	Anticholinergics, Quaternary	Clidinium W/Chlordiazepoxide Glycopyrrolate Propantheline Bromide
A	J2D	Anticholinergics/Antispasmodics	Dicyclomine
D	J3A	Ganglionic Stimulants	None
D	J5A	Adrenergic Agents, Catecholamines	None
D	J5B	Adrenergics, Aromatic Non-Catecholamines (Amphetamine)	None
A	J5C	Adrenergic Agents, Non-Aromatic	All
A	J5D	Beta-Adrenergic Agents	Albuterol Brethine Combivent Foradil Maxair Autohaler Metaproterenol Sulfate Serevent Diskus Terbutaline Sulfate Xopenex
A	J5E	Sympathomimetic Nasal Decongestants	Afrin Ephedrine Sulfate Pseudoephedrine
A	J5F	Anaphylaxis Therapy Agents	Ana-Kit Epipen
A	J5G	Beta-Adrenergics And Glucocorticoids Combination	Advair Diskus
A	J5H	Adrenergic Vasopressor Agents	Midodrine HCl
A	J7A	Alpha/Beta Adrenergic Blocking Agents	Labetalol
A	J7B	Alpha-Adrenergic Blocking Agents	Doxazosin Mesylate Prazosin Terazosin
PA	J7C	Beta-Adrenergic Blocking Agents	None
PA	J7E	Alpha-Adrenergic Blocking Agent/ Thiazide Combination	None
D	J8A	Anorexic Agents	None
A	J9A	Intestinal Motility Stimulants	Metoclopramide
PA	J9B	Antispasmodic Agents	None

Skin/Subcutaneous Tissue

Status	GC3	Therapeutic Class Description	Preferred Drug(s)
A	L0B	Topical/Mucous Membrane/Sub-Q Enzyme Preps	Santyl
PA	L1A	Antipsoriatic Agents, Systemic	None
D	L1B	Acne Agents, Systemic	None
A	L2A	Emollients	All
A	L3A	Protectives	All
A	L3P	Antipruritics, Topical	Caladryl Diphenhydramine
A	L4A	Astringents	All
D	L5A	Keratolytics	None
D	L5B	Sunscreens	None
D	L5C	Abrasives	None
D	L5E	Antiseborrheic Agents	None

Status	GC3	Therapeutic Class Description	Preferred Drug(s)
PA	L5F	Antipsoriatic Agents, Topical	None
D	L5G	Rosacea Agents, Topical	None
D	L5H	Acne Agents, Topical	None
A	L5I	Wound Healing Agents, Local	Hyalofill-F Peviderm Wound Care Sol
A	L6A	Irritants/Counter-Irritants	All
D	L7A	Shampoos	None
D	L8A	Deodorants	None
D	L8B	Antiperspirants	None
A	L9A	Miscellaneous Topical Agents	All
D	L9B	Vitamin A Derivatives	None
D	L9C	Hypopigmentation Agents	None
D	L9D	Topical Hyperpigmentation Agents	None
D	L9F	Cosmetic/Skin Coloring/Dye Agents, Topical	None
D	L9G	Skin Tissue Replacement	None
D	L9I	Vitamin A Derivatives, Topical Cosmetic Agents	None

Blood

Status	GC3	Therapeutic Class Description	Preferred Drug(s)
PA	M0B	Plasma Proteins	None
A	M0D	Plasma Expanders	All
PA	M0E	Antihemophilic Factors	None
PA	M0F	Factor IX Preparations	None
A	M3A	Occult Blood Tests	All
PA	M4A	Blood Sugar Diagnostics	None
A	M4B	IV Fat Emulsions	All
D	M4E	Lipotropics	None
D	M4G	Hyperglycemics	None
A	M9A	Topical Hemostatics	All
A	M9D	Antifibrinolytic Agents	All
A	M9E	Thrombin Inhibitors, Hirudin Type Agents	All
A	M9F	Thrombolytic Enzymes	All
A	M9J	Citrates As Anticoagulants	All
A	M9K	Heparin Preparations	Arixtra Fragmin Heparin Sodium Innohep Lovenox Orgaran
A	M9L	Oral Anticoagulants, Coumarin Type	Coumadin Warfarin Sodium
PA	M9P	Platelet Aggregation Inhibitors	None

Bone Marrow

Status	GC3	Therapeutic Class Description	Preferred Drug(s)
PA	N1B	Hematinics, Other	None
D	N1C	Leukocyte (WBC) Stimulants	None
PA	N1D	Platelet Reducing Agents	None

Endocrine System (Except Gonads)

Status	GC3	Therapeutic Class Description	Preferred Drug(s)
D	P0B	Follicle Stimulating Hormones	None
D	P1A	Growth Hormones	None
D	P1B	Somatostatic Agents	None
D	P1E	Adrenocorticotrophic Hormones	None
D	P1F	Pituitary Suppressive Agents	None
D	P1H	Growth Hormone Releasing Hormone	None
D	P1L	Luteinizing Hormone Releasing-Hormone	None
D	P1M	LHRH/GNRH Agonist Analog Pituitary Suppressants	None
D	P1N	LHRH Antagonist Pituitary Suppressant Agents	None
D	P1P	LHRH/GNRH Agonist Pituitary Suppressants-C Prec Puberty	None
D	P1Q	Growth Hormone Receptor Antagonists	None
D	P1U	Metabolic Function Diagnostics	None
D	P2B	Antidiuretic And Vasopressor Hormones	None
A	P3A	Thyroid Hormones	Bio-Throid Cytomel Levothyroxine Sodium Synthroid Thyroid
D	P3B	Thyroid Function Diagnostic Agents	None
D	P3L	Antithyroid Preparations	None
PA	P4L	Bone Resorption Suppression Agents	None
A	P5A	Glucocorticoids	Cortisone Acetate Hydrocortisone Methylprednisolone Prednisolone Prednisone Celestone Dexamethasone Pulmicort Qvar Flovent Triamcinolone Acetonide
A	P5S	Mineralocorticoids	Fludrocortisone Acetate
D	P6A	Pineal Hormone Agents	None

Ear, Eye, Nose, Rectum, Topical, Vagina, Spec Senses

Status	GC3	Therapeutic Class Description	Preferred Drug(s)
D	Q2U	Eye Diagnostic Agents	None
A	Q3A	Rectal Preparations	Anusol-HC Hemorrhoidal HC Proctofoam-HC
A	Q3B	Rectal/Lower Bowel Prep, Glucocorticoid, Non-Hemorrhoidal	Cortiform Hydrocortisone

Status	GC3	Therapeutic Class Description	Preferred Drug(s)
A	Q3D	Hemorrhoidal Preparations	Americaine Hemorrhoidal Analpram-HC Anusert Anusol Hemorrhoid Cream Tronolane
PA	Q3E	Chronic Inflm Colon Dx 5 - Aminosalicylates	None
A	Q3H	Hemorrhoidal Preparations, Local Anesthetics	Nupercainal
A	Q3S	Laxatives, Local/Rectal	Adult Suppository Bisac-Evac Disposable Enema Glycerin
PA	Q4A	Vaginal Preparations	None
PA	Q4B	Vaginal Antiseptics	None
PA	Q4F	Vaginal Antifungals	None
D	Q4K	Vaginal Estrogen Preparations	None
PA	Q4S	Vaginal Sulfonamides	None
PA	Q4W	Vaginal Antibiotics	None
D	Q5A	Topical Preparations, Miscellaneous	None
A	Q5B	Topical Preparations, Antibacterials	Betadine Boric Acid Cetaphil Chlorhexidine Gluconate Clioquinol W/Hydrocortisone Iodine Iodochlorhydroxyquin W/HC Iodosorb Povidone-Iodine Silver Nitrate Zephiran Chloride
D	Q5C	Topical Preparations, Hypertrichotic Agents	None
A	Q5E	Topical Antiinflammatory, Non-Steroidal	All
A	Q5F	Topical Antifungals	Absorbine Jr. Clotrimazole Clotrimazole-Betamethasone Desenex Econazole Nitrate Fungi-Guard Fungi-Nail Fungoid Gentian Violet Ketoconazole Lamisil AT Nystatin W/Triamcinolone Lotrimin AF Mentax Micatin Miconazole Nitrate Nizoral Nystatin Penlac Tinactin Tolnaftate

Status	GC3	Therapeutic Class Description	Preferred Drug(s)
A	Q5H	Topical Local Anesthetics	Americaine Cetacaine Dermacaine Dermoplast Dibucaine Ethyl Chloride Lidocaine Prax Solarcaine Vagisil Xylocaine
A	Q5K	Topical Immunosuppressive Agents	Elidel
PA	Q5N	Topical Antineoplastics	None
A	Q5P	Topical Antiinflammatory Preparations	Amcinonide Betamethasone Dipropionate Betamethasone Valerate Clobetasol Propionate Desonide Desoximetasone Diflorasone Diacetate Triamcinolone Acetonide Embeline Fluocinolone Acetonide Fluocinonide Hydrocortisone Mometasone Furoate Nupercainal HC
A	Q5R	Topical Antiparasitics	Eurax Lice Treament Lindane Permethrin
A	Q5S	Topical Sulfonamides	Plexion Silver Sulfadiazine Sodium Sulfacetamide/Sulfur
A	Q5V	Topical Antivirals	Abreva Denavir Zovirax
A	Q5W	Topical Antibiotics	All
A	Q5X	Topical Antibiotics/Antiinflammatory, Steroidal	Neomycin W/Hydrocortisone
A	Q6A	Eye Preparations, Miscellaneous	All
A	Q6C	Eye Vasoconstrictors (Rx Only)	All
A	Q6D	Eye Vasoconstrictors (OTC Only)	All
A	Q6E	Eye Irrigations	All

Status	GC3	Therapeutic Class Description	Preferred Drug(s)
A	Q6G	Miotics And Other Intraocular Pressure Reducers	Azopt Betaxolol Brimonidine Tartrate Carteolol Cosopt Epinal Iopidine Isopto Carbachol Levobunolol Metipranolol Ocusert Pilo-20 P1E1 P2E1 P4E1 P6E1 Phospholine Iodide Pilocarpine Piloptic Timolol Maleate Trusopt Xalatan
A	Q6H	Eye Local Anesthetics	None
A	Q6I	Eye Antibiotic-Corticoid Combinations	Cortomycin Dexasporin Methadex Neomycin W/Dexamethasone Neomycin/Bacitracin/Polymixin/HC Neomycin/Polymyxin/Dexamethasone Neomycin/Polymyxin/HC Poly-Pred Pred-G Tobradex Triple Antibiotic HC
A	Q6J	Mydriatics	Atropine Sulfate Cyclopentolate Dipivefrin Epifrin Glaucon Homatropaire Tropicamide
A	Q6P	Eye Antiinflammatory Agents	Dexamethasone Sod Phosphate Diclofenac Sodium Fluorometholone Flurbiprofen Sodium HMS Lotemax Pred Mild Prednisolone Acetate Voltaren
A	Q6R	Eye Antihistamines	Livostin Patanol Zaditor
A	Q6S	Eye Sulfonamides	Sulfacetamide Sodium Sulfacetamide W/Prednisolone
A	Q6T	Artificial Tears	All

Status	GC3	Therapeutic Class Description	Preferred Drug(s)
A	Q6U	Ophthalmic Mast Cell Stabilizers	Alomide Cromolyn Sodium
A	Q6V	Eye Antivirals	Trifluridine
A	Q6W	Eye Antibiotics	Bacitracin Bacitracin/Polymyxin Chloramphenicol Ciloxan Erythromycin Gentamicin Sulfate Neomycin/Bacitracin/Polymyxin Ocuflox Polymyxin B Sulfate/Trimethoprim Tobramycin Sulfate Triple Antibiotic Zymar
A	Q6Y	Eye Preparations, Miscellaneous (OTC Only)	All
A	Q7A	Nose Preparations, Miscellaneous (Rx Only)	Ipratropium Bromide
A	Q7C	Nose Preparations, Vasoconstrictors (Rx Only)	All
A	Q7D	Nose Preparations, Vasoconstrictors (OTC Only)	All
A	Q7E	Nasal Antihistamine	Astelin
A	Q7P	Nose Preparations, Antiinflammatory	Flonase Flunisolide Nasacort Nasonex Vancenase
A	Q7W	Nose Preparations, Antibiotics	Bactroban Nasal
A	Q7Y	Nose Preparations, Miscellaneous (Otc Only)	All
A	Q8B	Ear Preparations, Miscellaneous Antiinfectives	Acetasol Acetic Acid Acetic Acid W/Hydrocortisone
A	Q8F	Ear Preparations, Anti-Inflammatory-Antibiotics	Cipro HC
A	Q8H	Ear Preparations, Local Anesthetics	A/B Otic Antipyrine W/Benzocaine
D	Q8R	Ear Preparations, Ear Wax Removers	None
A	Q8W	Ear Preparations, Antibiotics	Antibiotic Ear Solution Floxin Neomycin/Polymyxin/HC
A	Q8Y	Ear Preparations, Miscellaneous (OTC Only)	None
D	Q9B	Benign Prostatic Hypertrophy/ Micturition Agents	None

Kidney/Urinary Tract

Status	GC3	Therapeutic Class Description	Preferred Drug(s)
PA	R1B	Osmotic Diuretics	None
PA	R1E	Carbonic Anhydrase Inhibitors	None
PA	R1F	Thiazide Diuretics And Related Agents	None
PA	R1H	Potassium Sparing Diuretics	None
PA	R1K	Miscellaneous Diuretics	None

Status	GC3	Therapeutic Class Description	Preferred Drug(s)
PA	R1L	Potassium Sparing Diuretics In Combination	None
PA	R1M	Loop Diuretics	None
D	R1R	Uricosuric Agents	None
A	R1S	Urinary Ph Modifiers	Citrolith Cytra-2 K-Phos Original Potassium Citrate/Citric Acid Renacidin Sodium Citrate & Citric Acid Urocit-K
D	R1U	Renal Function Diagnostic Agents	None
D	R2U	Urinary Tract Radiopaque Diagnostics	None
PA	R3U	Urine Glucose Test Aids	None
PA	R3V	Miscellaneous Urine Test Aids	None
PA	R3W	Urine Acetone Test Aids	None
PA	R3Y	Urine Multiple Test Aids	None
PA	R4A	Kidney Stone Agents	None
PA	R5A	Urinary Tract Anesthetic/Analgesic Agents	None

Locomotor System

Status	GC3	Therapeutic Class Description	Preferred Drug(s)
D	S2A	Colchicine	None
A	S2C	Gold Salts	Solgranal Suspension
PA	S2H	Anti-Inflammatory/Antiarthritic Agents, Miscellaneous	None
PA	S2I	Anti-Inflammatory, Pyrimidine Synthesis Inhibitor	None
PA	S2J	Anti-Inflammatory, Tumor Necrosis Factor Inhibitor	None
PA	S2P	NSAIDs, Cyclooxygenase 2 Inhibitor-Type & Proton Pump Inhib Comb	None
D	S7A	Neuromuscular Blocking Agents	None

Miscellaneous Drugs And Pharmaceutical Adjuvants

Status	GC3	Therapeutic Class Description	Preferred Drug(s)
D	U5A	Homeopathic Drugs	None
D	U5B	Herbal Drugs	None
D	U5F	Animal/Human Derived Agents	None
A	U6A	Pharmaceutical Adjuvants, Tableting Agents	All
A	U6B	Pharmaceutical Adjuvants, Coating Agents	All
A	U6C	Thickening Agents	All
A	U6F	Hydrophilic Cream/Ointment Bases	All
A	U6H	Solvents	All
A	U6N	Vehicles	All
A	U6S	Propellants	All
PA	U6W	Bulk Chemicals, O.U.	None
A	U7A	Suspending Agents	All
A	U7D	Surfactants	All

Status	GC3	Therapeutic Class Description	Preferred Drug(s)
A	U7H	Antioxidants	All
A	U7K	Flavoring Agents	All
A	U7N	Sweeteners	All
A	U7P	Perfumes	All
A	U7Q	Coloring Agents	All

Neoplasms

Status	GC3	Therapeutic Class Description	Preferred Drug(s)
PA	V1A	Alkylating Agents	None
PA	V1B	Antimetabolites	None
PA	V1C	Vinca Alkaloids	None
PA	V1D	Antibiotic Antineoplastics	None
PA	V1E	Steroid Antineoplastics	None
PA	V1F	Miscellaneous Antineoplastics	None
PA	V1I	Chemotherapy Antidotes	None
PA	V1J	Antiandrogenic Agents	None
PA	V1K	Antineoplastics Antibody/Antibody-Drug Complexes	None
D	V1O	Antineoplastic Lhrh Agonists, Pituitary Suppressant	None
PA	V1Q	Antineoplastic Systemic Enzyme Inhibitor	None
PA	V1R	Photoactivated, Antineoplastic Agents, Systemic	None
PA	V1T	Selective Estrogen Receptor Modulators (Serm)	None

Anti-Infecting Agents

Status	GC3	Therapeutic Class Description	Preferred Drug(s)
A	W1A	Penicillins	Amoxicillin Trihydrate W/Potassium Claulanate Amoxicillin Ampicillin Dicloxacillin Sodium Penicillin V Potassium
A	W1C	Tetracyclines	Doxycycline Minocycline Tetracycline
A	W1D	Macrolides	Biaxin Ery-Tab Erythromycin Erythromycin W/Sulfisoxazole Zithromax
A	W1F	Aminoglycosides	All
A	W1G	Antitubercular Antibiotics	Rifampin Rimactane
A	W1J	Vancomycin And Derivatives	Vancocin
A	W1K	Lincosamides	Clindamycin Lincomycin
A	W1L	Topical Antibiotics	All
A	W1M	Streptogramins	All
A	W1N	Polymyxin And Derivatives	Colistimethate Sodium Polymyxin B Sulfate
A	W1O	Oxazolidones	Zyvox

Status	GC3	Therapeutic Class Description	Preferred Drug(s)
A	W1P	Oxabeta-Lactams	All
A	W1Q	Quinolones	Avelox Ciprofloxacin Levaquin Ofloxacin Tequin
A	W1S	Thienamycins	All
A	W1W	Cephalosporins-1st Generation	Cefadroxil Cephalexin
A	W1X	Cephalosporins-2nd Generation	Cefaclor Ceftin Cefzil
A	W1Y	Cephalosporins-3rd Generation	Suprax Spectracef
A	W1Z	Cephalosporins-4th Generation	All
A	W2A	Absorbable Sulfonamides	Azo-Gantrisin Gantrisin Sulfadiazine Sulfamethoxazole/Trimethoprim Sulfasalazine Sulfisoxazole
A	W2E	Antitubercular Agents	Ethambutol Isoniazid Pyrazinamide
A	W2F	Nitrofuran Derivatives	Furadantin Macrobid Nitrofurantoin
A	W2G	Antibacterial Chemotherapeutic Agents, Misc.	Methenamine Mandelate Trimethoprim Urinary Antiseptic Usept
A	W2Y	Miscellaneous Antiinfectives	All
A	W3A	Antifungal Antibiotics	Fulvicin P/G Nystatin
A	W3B	Antifungal Agents	Ketoconazole Mycelex Diflucan Lamisil Sporanox Vfend
A	W4A	Antimalarial Drugs	Aralen Chloroquine Phosphate Daraprim Fansidar Halfan Hydroxychloroquine Sulfate Malarone Mefloquine Primaquine Quinine Sulfate
D	W4C	Amebacides	None
A	W4E	Trichomonacides	Metronidazole
D	W4K	Miscellaneous Antiprotozoal Drugs	None
D	W4L	Anthelmintics	None
D	W4M	Topical Antiparasitics	None

Status	GC3	Therapeutic Class Description	Preferred Drug(s)
D	W4P	Antileprotics	None
D	W4Q	Insecticides	None
PA	W5A	Antivirals	None
A	W5C	Antivirals, HIV-Specific, Protease Inhibitors	All
PA	W5D	Antiviral Monoclonal Antibodies	None
PA	W5E	Hepatitis A Treatment Agents	None
PA	W5F	Hepatitis B Treatment Agents	None
PA	W5G	Hepatitis C Treatment Agents	None
A	W5I	Antivirals, HIV-Spec, Nucleotide Analog, Rvrse Trans Inhib	All
A	W5J	Antivirals, HIV-Spec, Nucleoside Analog, Rvrse Trans Inhib	All
A	W5K	Antivirals, HIV-Spec, Non-Nucleoside Rvrse Trans Inhib	All
A	W5L	Antivirals, HIV-Spec, Nucleoside Analog, RTI Combos	All
A	W5M	Antivirals, HIV-Specific, Protease Inhibitor Combinations	All
D	W6A	Drugs To Treat Sepsis Syndrome, Non-Antibiotic	None
D	W7B	Exanthematous And Tumor Causing Virus Vaccines	None
D	W7C	Influenza Virus Vaccines	None
D	W7J	Arthropod-Borne And Other Neurotoxic Virus Vaccines	None
A	W7K	Antisera	All
D	W7L	Gram Positive Cocci Vaccines	None
D	W7M	Gram Negative Bacilli (Non-Enteric) Vaccines	None
D	W7N	Toxin Producing Bacteria Vaccines And Toxoids	None
A	W7S	Antivenins	All
D	W7T	Antigenic Skin Tests	None
D	W7U	Hymenoptera Extracts	None
D	W7W	Miscellaneous Therapeutic Allergenic Extracts	None
D	W7Z	Combination Vaccine And Toxoid Preparations	None
A	W8A	Heavy Metal Antiseptics	All
A	W8B	Surface Active Agents	All
A	W8D	Oxidizing Agents	All
A	W8E	Antiseptics, General	All
A	W8F	Irrigants	All
D	W8G	Miscellaneous Antiseptics	None
D	W8H	Mouthwashes	None
A	W8J	Miscellaneous Antibacterial Agents	All
D	W8T	Preservatives	None

Body As A Whole

Status	GC3	Therapeutic Class Description	Preferred Drug(s)
D	Z1D	Enzyme Replacements (Ubiquitous Enzymes)	None
D	Z1E	Antioxidant Agents	None

Status	GC3	Therapeutic Class Description	Preferred Drug(s)
A	Z2A	Antihistamines	Chlorpheniramine Clemastine Fumarate Cyproheptadine Dexchlorpheniramine Maleate Diphenhydramine Hydroxyzine Loratadine Polaramine Promethazine
PA	Z2E	Immunosuppresives	None
A	Z2F	Mast Cell Stabilizers	Cromolyn Sodium
PA	Z2G	Immunomodulators	None
D	Z2H	Systemic Enzyme Inhibitors	None
D	Z2M	Immunosupp - Monoclon Antibody Inhibiting T Lymph Function	None
A	Z2N	1st Generation Anthistamine-Decongestant Combinations	Bromfed Brompheniramine W/Pseudoephedrine Carbinoxamine Decongestant Plus Pseudoephedrine W/Chlorpheniramine Triprolidine W/Pseudoephedrine
A	Z2O	2nd Generation Anthistamine-Decongestant Combinations	Alavert Claritin-D 12 Hour
A	Z4B	Leukotriene Receptor Antagonists	Singulair
D	Z9D	Diagnostic Preparations, OU	None

APPENDIX H
DOCUMENTATION REQUIREMENTS(1)

In addition to the documentation requirements published by the American Medical Association in the Physicians' Current Procedural Terminology book, the department or Self-Insurer has additional reporting and documentation requirements to adequately manage industrial insurance claims.

The department or self-insurer may request the following reports. No additional amount is payable for these reports as they are required to support billing. The department's Report of Accident or the Self-Insurer's Physician's Initial Report are payable separately. "Narrative report" as used in the table below merely signifies the absence of a specific form. Office/chart notes are expected to be legible and in the SOAP-ER format as specified under **CHARTING FORMAT**. Level of service is based on the documentation of services and the medical/clinical complexity as defined in the CPT Evaluation & Management (E/M) coding requirements.

Service	Code(s)	Requirements
Case Management and Telephone Calls	CPT® 99361-99373	Documentation in the medical record should include: • the date, • the participants and their titles, • the length of the call or visit, • the nature of the call or visit, and • any decisions made during the call.
Chiropractic Care Visit	Local 2050A & 2051A	Office/chart notes
	Local 2052A	Narrative report or office/chart notes showing the increased clinical complexity
Consultation	CPT® 99241-99275	Narrative consultation report (WAC 296-20-051) • due to the insurer within 15 days of consult
Critical Care	CPT® 99291 & 99292	Narrative report or daily chart notes
Emergency Room	CPT® 99281 & 99282	Report of accident and ER report/notes in the hospital medical record.
	CPT® 99283-99285	Report of accident and ER report
Hospital	CPT® 99221-99223	Report of accident and H&P
	CPT® 99231-99238	Narrative report or an interval progress note
Nursing Facility	CPT® 99301-99303	Narrative report or facility notes and orders
	CPT® 99311	Narrative or an interval progress note
	CPT® 99312 & 99313	Narrative report or facility notes and orders
Office Visit	CPT® 99201 & 99202	Report of accident and office/chart notes due to the insurer in 5 days
	CPT® 99203-99205	Report of accident and office/chart notes due to the insurer in 5 days
	CPT® 99211 & 99212	Office/chart notes
	CPT® 99213-99215	Narrative report or office/chart notes showing the increased level of complexity
Prolonged Services	CPT® 99354-99359	Narrative or office/chart notes showing dates and times
Psychiatric Services	CPT® 90804-90853	Narrative report
Standby	CPT® 99360	Narrative or office/chart notes showing dates and times
Miscellaneous	CPT® 99288 & 99499	Narrative report or emergency transport notes

(1) See WAC 296-20-06101 for any additional information.

INDEX
MEDICAL AID RULES AND FEE SCHEDULES

- Only items with page numbers can be found within the policy section.
- **RULES** can be found under **Medical Aid Rules**.
- **FEE SCHEDULES** can be found under **Fee Schedules**.

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